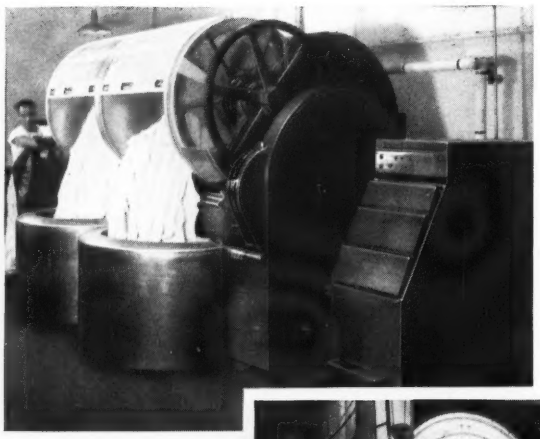
THE CANADIAN HOSPITAL

OFFICIAL JOURNAL
CANADIAN HOSPITAL COUNCIL

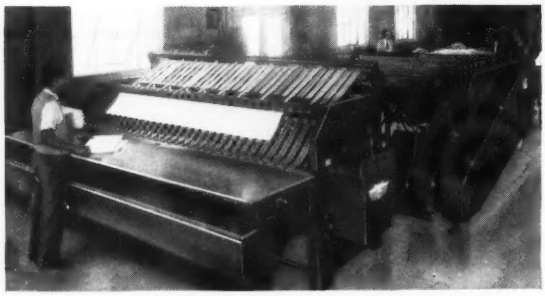
AUGUST, 1948

CANADIAN

Modernized the Laundry Department at 525-Bed QUEEN OF ANGELS Hospital, Los Angeles



In modernized laundry at Queen of Angels Hospital, this 42 x 84" CASCADE Automatic Unloading Washer with Companion Control washes automatically, unloads mechanically into NOTRUX Extractor Containers. At right, loaded Containers are quickly hoisted into and out of NOTRUX Extractor.



8-ROLL STREAMLINE Flatwork Ironer with TRUMATIC Folder irons and automatically folds large pieces at high speed; saves labor of 2 operators.

problem

A 175-bed addition at Queen of Angels Hospital, Los Angeles, seriously overburdened the laundry department. Production costs mounted. Laundering capacity had to be increased in minimum space.

solution

Hospital authorities called in our Laundry Advisor who made a thorough survey and submitted recommendations. Hospital then installed equipment shown.

results

Hospital reports laundering capacity has been doubled in only ⅓ more space. Plenty of clean linens are always available. Linen inventory has been reduced. Quality of laundering is much better. Savings made by the modern, labor-saving equipment amount to $12,000 yearly.

Our Laundry Advisor will be glad to help you solve *your* laundry problem. There's no cost or obligation. WRITE TODAY.

Remember...

Every Department of the Hospital Depends on the Laundry.

The CANADIAN LAUNDRY MACHINERY CO. LIMITED

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WESTERN REPRESENTATIVES—Stanley Brock Limited, Winnipeg, Calgary, Vancouver.

Bovine blood can be collected and handled under carefully controlled, sanitary conditions. Protein Hydrolysate, Baxter, is prepared from the plasma of this blood because plasma proteins properly processed are good proteins*. Enzymatically digested, the proteins are converted into amino acids and peptides with a minimum change in structure. A new booklet, Protein Hydrolysate, Baxter, is yours for the asking. Baxter Laboratories, Morton Grove, Illinois.

Journal of the American Dietetic Assn. Vol. 23 #10 Page 841 October 1947.

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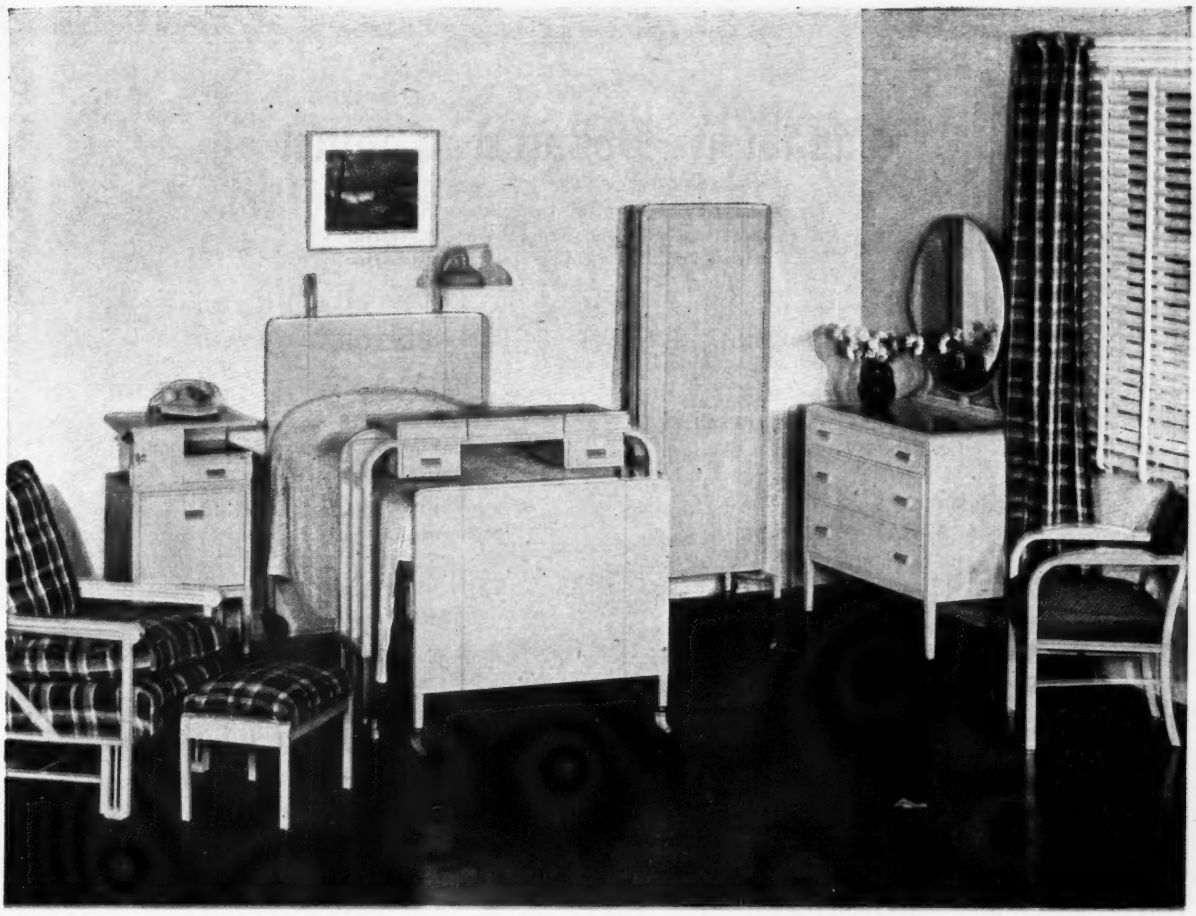

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Simmons Hospital Furniture provides, in its efficient, functional design and sturdy steel construction, all the qualities desired to meet exacting hospital requirements.

The product of years of specialized research, it is available in a complete range (beds, tables, screens, dressers, chairs, etc.) and in a selection of attractive harmonizing finishes. (A typical example is the set, "Simmons Hospital Room No. 1", illustrated above.) Each piece maintains the established Simmons tradition of highest quality materials and mechanical perfection.

If special equipment is needed for particular requirements, our expert knowledge and experience are at your service for its development. Write to our nearest divisional office for hospital catalogue.

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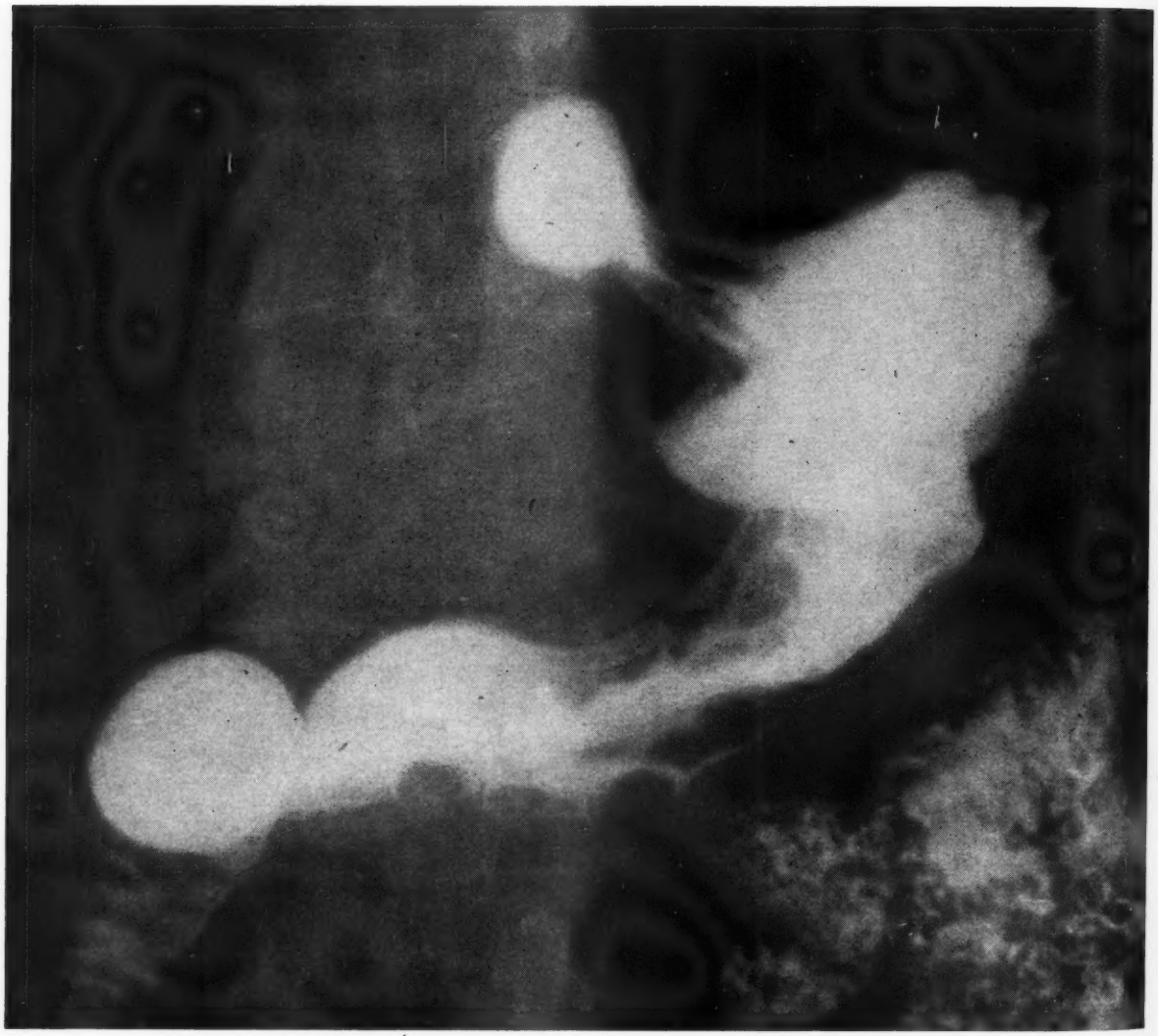
rays *that treat malignancies*



Nearly half of all cancer deaths are caused by malignant neoplasms of the gastro-intestinal tract.

For the control of symptoms . . . for the relief of pain . . . x-ray therapy has been of use. And, increasingly, there have been cures. Still there is much which remains unknown.

To throw light upon that unknown the General Electric Research Laboratory is at work on ever more useful x-ray therapy apparatus. For upon G.E. rest the responsibilities of a leader. What is the measure of leadership? *The leader goes before.* General Electric X-Ray achievements – the Coolidge hot cathode and rotating anode tubes, the million-volt x-ray therapy unit, the G-E Betatron – have marked out the rungs in the ladder of x-ray progress.

Leadership grows steadily. Within two years of Roentgen's discovery, G-E X-Ray was building x-ray equipment and has since literally grown up with the art. *Leadership must be deserved.* General Electric enjoys the confidence of the medical profession because physicians know that when they own G-E they own the best.

of the abdomen

The G-E Maximar 250

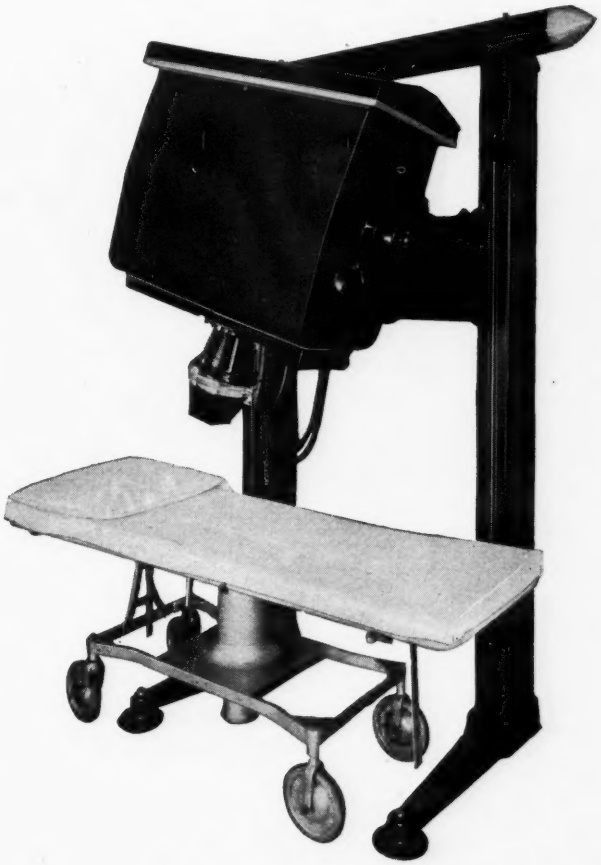
The G-E Maximar 250 may be operated continuously at any voltage from 80 kvp to 250 kvp at from 2 to 15 ma. In a single apparatus the Maximar 250 provides a therapeutic range from superficial lesions to deep-seated malignancies.

Easy to position. Vertical adjustment and transverse angulation are made by two motors controlled by a single switch.

Heavy duty. Within its wide voltage and milliamperage range, the Maximar 250 may be operated continuously. There is no need for cooling-off periods. A heavy flow of patients may be handled with complete convenience.

Dependable. Oil-immersion of the high-voltage circuit brings safety from electrical shock and consistent performance unhampered by dust, humidity or altitude. And like all G-E equipment, the Maximar 250 is built of units designed with experience and skill.

For therapy at voltages up to 400 kvp, investigate the Maximar 400. For supervoltage radiation, investigate the one- and two-million-volt x-ray therapy units and the new G-E Betatron. This much is sure—that within the General Electric line of x-ray therapy apparatus is the one unit that exactly fits your requirements. Why not have a G-E installation engineer call? General Electric X-Ray Corporation, Dept. H-29, 4855 McGeoch Ave., Milwaukee 14, Wisc.



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For The Urologist—
The Utmost In Electrosurgical Utility!

WAPPLER
SURGICAL UNIT
C-263

Designed primarily to meet the exacting requirements of urologic electro-surgery, this WAPPLER SURGICAL UNIT combines great power with precise and **blended** control (when required) of cutting and coagulating currents in any proportion desired. For transurethral resections, and other urologic procedures, this high frequency unit cuts and coagulates with such ease and speed as to expedite materially the most difficult techniques. When the employment of tissue cutting and haemostatic currents is indicated in other fields, such as General, Thoracic, Proctologic, Ophthalmologic Surgery, etc., the remarkable simplicity of control, complete dependability and uniformly excellent results achieved with the WAPPLER C-263 recommend it as the instrument of choice.

Splashproof Footswitch permits ready current selection and control by operator, once rheostats are set.

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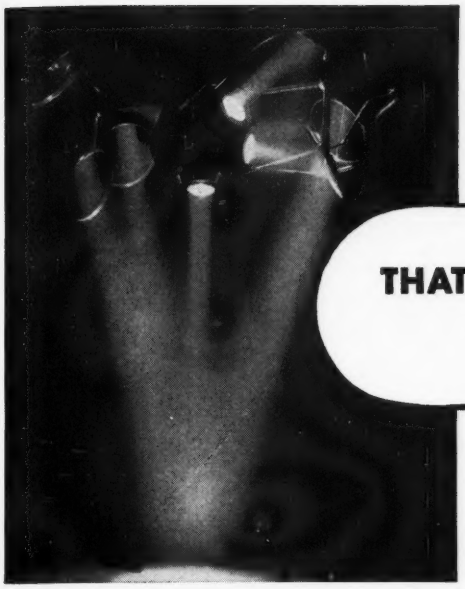

SURGICAL LIGHTING

THAT CONSERVES THE SURGEON'S ENERGY AND PREVENTS EYESTRAIN

Soft, White, Glareless Illumination At Any Angle

• The Operay Multibeam projects a powerful compound beam of light to the operating field from many directions—penetrates to the depth of the surgical cavity, despite hands, heads and shoulders of the surgeon and assistants over the operating field. The light rays from a 250-watt projection lamp are reflected from the internal mirrors within the projector, through six condensing lenses to corresponding external mirrors, and thence downward to the operating field. Completely adjustable within the area of an 84-inch circle over and around the operating table. (Made also in explosion-proof models, for use where explosive anesthetic gases are used.)

• Surg-O-Ray lighting fixtures provide excellent flexibility and intensity of illumination for operating room and delivery room use—may be raised, lowered, tipped or tilted and turned at any desired angle. Standard Surg-O-Ray fixture is equipped with twin-filament projection lamp. Each filament burns separately, or both filaments burn simultaneously when double intensity is desired. Made in portable stand and ceiling-hung models. Emergency model (battery equipped) has double-filament lamp—one filament operates on regular house current; second filament is connected to the fixture battery and operates from the battery current when regular current fails. When desired, ceiling Surg-O-Ray fixtures can be equipped with auxiliary ceiling lights for general room illumination.

Write for catalog on surgical lighting.

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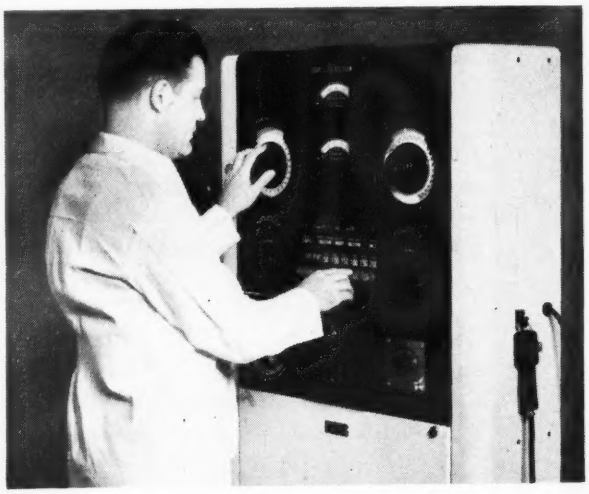
Across the Desk

"Pushbutton"-type Centralinear Control

A streamlined, "Pushbutton"-type Centralinear vertical control has been perfected for 200 ma x-ray equipment by General Electric X-Ray Corp. of Milwaukee.

Outstanding feature of the control is a "Mechanical-Brain" Milliamperage Selector, which reduces by 50% the number of movements required to make a radiographic exposure.

Versatility is also a major feature, as illustrated by the fact that it may be adapted to radiography, fluoroscopy, superficial therapy, spot-film radiography and photo-roentgenography (including angiocardiography).



Pressing the Milleamperage Selector button relieves the technician of 5 other operations: (1) selecting the proper tube, (2) selecting the desired focal spot, (3) setting the ma value, (4) choosing the milliameter scale, and (5) connecting the timer.

Another outstanding feature of the control is the accessibility of its interior mechanism through a front-opening panel, thus making it possible to service the unit quickly, without having to move it and cause costly shut-downs. Backlighting of the dials on the control reduces glare and shadow.

* * * *

Glass and Paint Service

Glass and paint today occupy a much more important position in Canada's economy than ten years ago. Consequently, the announcement by Mr. C. F. Wood, President of Hobbs Glass Limited, that his company has in the last five months opened new branches at Moncton, Three Rivers, Peterborough, Oshawa, Sudbury and Kitchener in order to give better and faster service to those using glass or paint on their products or in construction, is of interest.

Complete stocks will be carried at all points. Each of these new warehouses will be manned by a manager who has come up through the ranks and who has experience in handling glass and paint.

(Continued on page 16)

Service

For Electro-Medical Apparatus and Radio-Active Applications

Head Office and Laboratories, Toronto

Your X-Ray Equipment, like your automobile, should be constantly checked to maintain its topmost efficiency.

Now, during the summer season, is the ideal time to call in a fully qualified x-ray engineer, and discuss your x-ray problems with him while having your equipment tested and serviced.

As distributors for the famous **KELEKET** line of x-ray equipment we are in a position to offer constructive recommendations on your requirements. If you require maintenance or parts service at any time call X-Ray and Radium and a competent serviceman will be dispatched promptly.

OUR PLANNING SERVICE

We would be pleased to submit layout plans for the installation of new or the renovation of old x-ray departments in hospitals, clinics and private practices.

Radio-Active Materials and Accessories

Medical Radium in needles, tubes, cells and plaques of all sizes, with a complete line of accessories and applicators.

Radiation measuring instruments for dosage calculations and tracer equipment for use in research.

The highly skilled Physicists and Chemists of this Company are fully qualified to give expert assistance in planning and servicing Radium stocks, and specifying radiation equipment.

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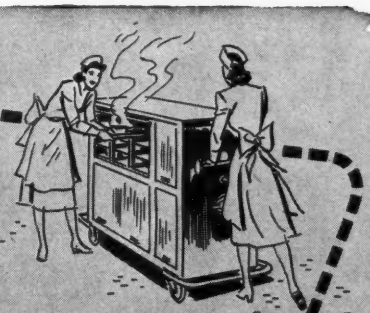
Monel



FOOD SERVICE EQUIPMENT FOR EVERY REQUIREMENT

MONEL is the ideal metal for food service equipment for it is strong, tough, rustproof and highly resistant to corrosion. It cleans easily and beautifully, for its silvery surface is glass-smooth, nonporous and extremely sanitary. Monel is a solid metal with no coating to chip, crack, peel or wear away . . . is unaffected by cleansing compounds. For food service equipment that will give years of trouble-free service, *specify* Monel. We will be pleased to advise you regarding Monel equipment for your requirements.

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Monel is the registered trade mark of The International Nickel Company.

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The International Nickel Company of Canada, Limited

KITCHEN INSTALLATIONS LTD.

2187 BLOOR ST. WEST, TORONTO **1075 BEAVER HALL HILL, MONTREAL**

Across the Desk

(Continued from page 16)

Salt Tablet Dispenser

There is no necessity for becoming steamed up about the hot weather with one of these handy salt tablet dispensers around. According to scientists, people suffer from heat and heat prostration because of the salt lost during excessive perspiration. In order to keep the body's cooling system functioning properly, additional salt must be taken to supplement that consumed in normal foods. Swallowing one to six tablets each day, it is said, is the simplest way of doing this. Salt tablets are especially recommended for those working in furnace rooms, laundries, kitchens and wherever the work results in considerable perspiration. Salt tablets and dispenser are distributed in Canada by Canadian Industries Limited.

* * * *

New Finger-Tip Air Conditioner Contains Glycols

A fast-acting spray which, it is stated, not only completely removes objectionable odours, but also substantially reduces the danger of infection communicated by air-borne germs is Ozium, a remarkable new product of G. H. Wood & Company Limited, Toronto.

Packed in highly concentrated form in small, steel cylindrical refills, each sufficient to freshen the air effectively in 20 to 30 average-size rooms or offices, Ozium costs an approximate one cent per room. It is dispensed from a new patented pressure sprayer only 4¾ inches high and 1½ inches in diameter. This dispenser is designed to fit the grip and is operated by a sensitive thumb-lever. When pressed, it releases a fine mist-like spray which quickly penetrates the entire area.

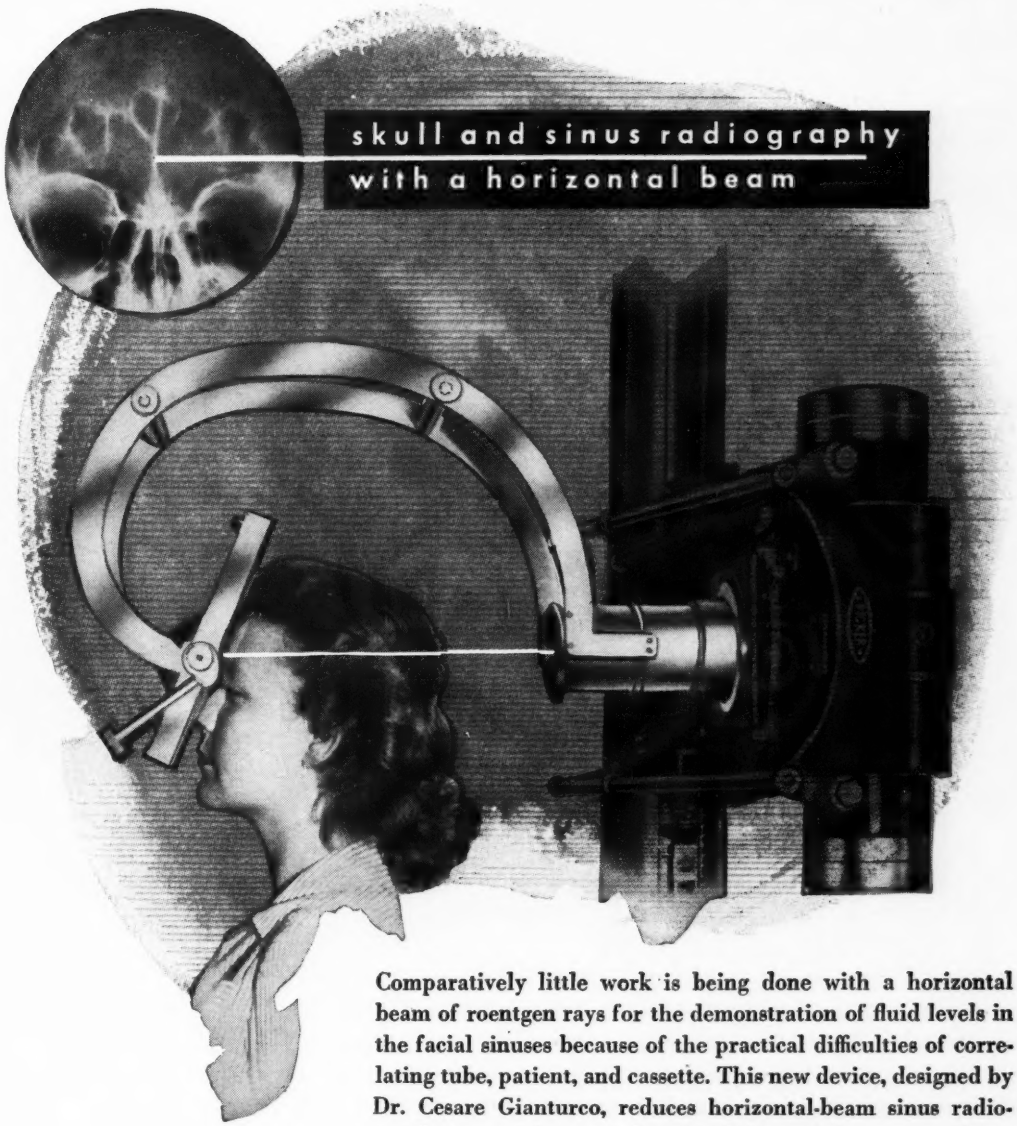
Ozium has a high content of glycols with which important strides have been made recently in combatting common colds and other infectious diseases communicated by air-borne bacteria.

* * * *

Portable Heat-retaining Food Server

The Thermo-Server, an odourless, heat-retaining and portable food server, is announced in production by The Sunline Company, Detroit. The unit consists basically of a thermostatically-controlled radiant glass heating element in a polished hardwood base, with a detachable "rigidized" aluminum roll-back hood.

(Concluded on page 20)



Comparatively little work is being done with a horizontal beam of roentgen rays for the demonstration of fluid levels in the facial sinuses because of the practical difficulties of correlating tube, patient, and cassette. This new device, designed by Dr. Cesare Gianturco, reduces horizontal-beam sinus radiography to a routine procedure involving even less time and manipulation than the use of angle boards and the vertical beam.

the GIANTURCO skull device

Picker

better accessories . . . for better radiography

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☐ Have your representative call to demonstrate the Gianturco device.

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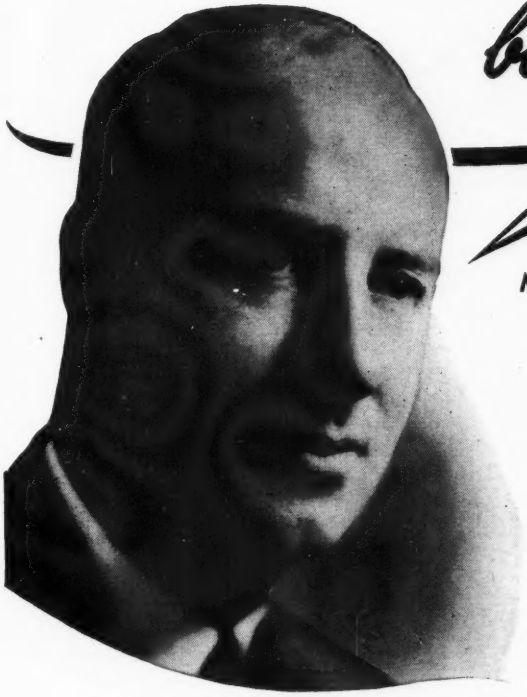
I'm sure I could not get along as well without the technical and business magazines



Mr. W. S. Kidd, Vice-President and General Manager of the E. B. Eddy Company, Hull, Que.

Many leading Canadian executives, have, like Mr. Kidd, found their business newspapers to be invaluable assets in everyday activities.
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137 WELLINGTON ST. W., TORONTO, ONT.

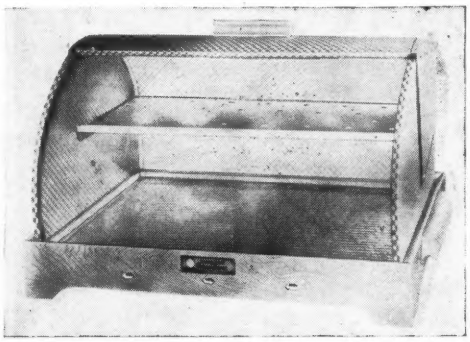
BNA-482

B.N.A. covers Canadian Business and Industry with merchandising, technical service and management publications.

Across the Desk

(Concluded from page 16)

Designed for quicker, more efficient and conomical service in hospitals, hotels, restaurants, schools, on railroads and steamships, and by caterers, the Thermo-server retains kitchen temperatures for hours, keeps food heated at its appetizing best—never too moist, never dried out.



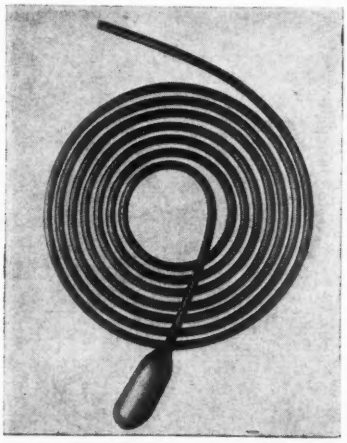
In use, the Thermo-Server is plugged in to any outlet, heats for ten minutes . . . food is then placed under the cover, cord detached, and the unit delivered to room or table. The thermostatically-controlled radiant glass heating element continues to give off infra-red heat. Food may be left in the Thermo-Server for up to two hours, without in any way changing its taste or appearance.

Further information may be secured by writing to The Sunline Company, 8661 Grand River Avenue, Detroit 4, Michigan.

* * * *

Child Size Cantor Tube

Clay-Adams Company, Inc., of New York, announces the availability of a Child Size Cantor Tube for intestinal intubation on infants and children. This new tube is 12 French, four feet long and has two series of



four holes each, each series 2" apart, and the holes ¾" from each other. The tubes carry the following markings: "S" (stomach) 14" from end of tube; "P" (pylorus) 19" from end of tube; and "D" (duodenum) 24" from end of tube.

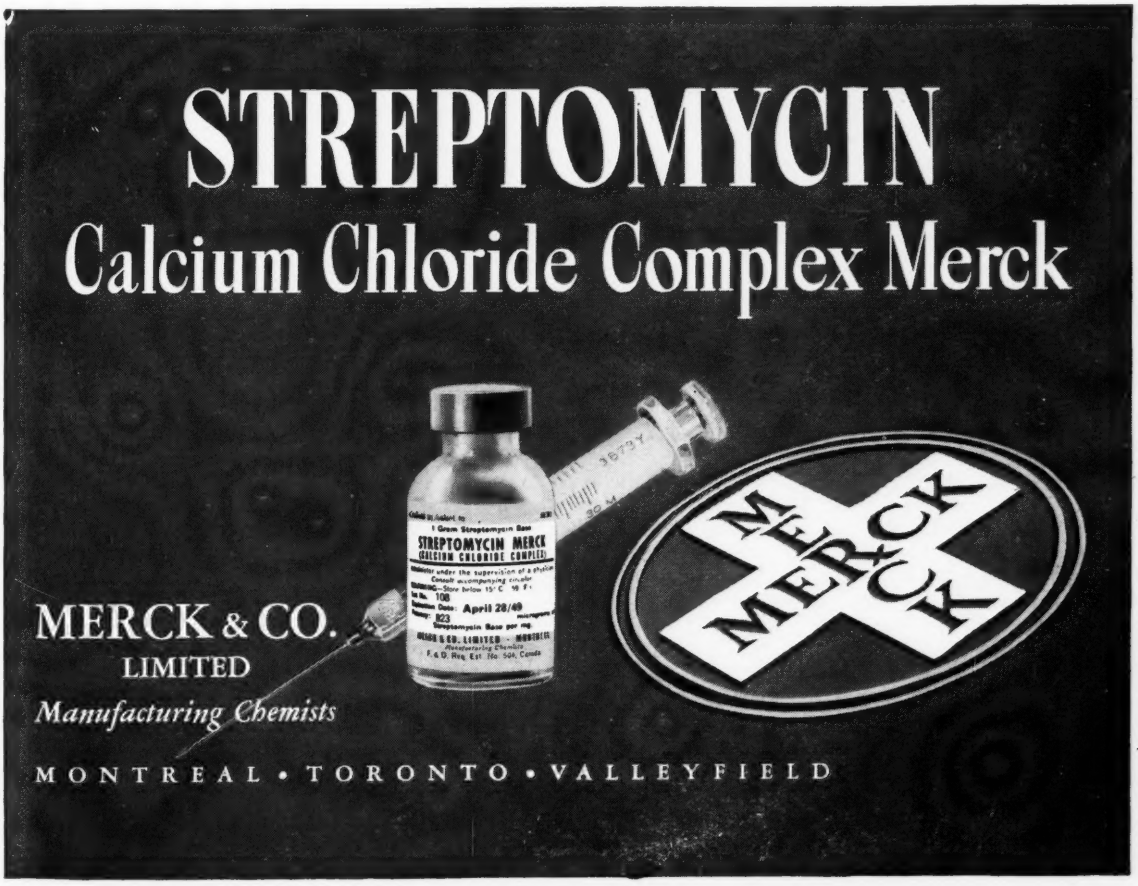
An Effective Adjunct in the Treatment of Certain Types of Tuberculosis

Clinical Experience has indicated that, as an adjunct to conventional therapy, Streptomycin is the most effective chemotherapeutic agent in the treatment of certain cases of tuberculosis. In selected cases, Streptomycin has been found effective in shortening the period of disability. The new, improved form of this valuable antibacterial agent — Streptomycin Calcium Chloride Complex Merck — provides three noteworthy advantages:

1 *increased purity*

2 *minimum pain following injection*

3 *uniform potency*



A *Tonic treatment* for nervous cases or circulatory disorders

C6351 hydrotherapeutic shower for free standing or enclosed installation. Each standard has four 3" heads. Faces are removable for cleaning. Top sprays have adjustable ball joints. Large overhead shower is adjustable. Standards are on 32" centers. Overall height 7 ft. 8 in.

The Crane hospital plumbing line includes everything necessary for every department in the hospital.

A CRANE hydrotherapeutic shower is an important addition to the hydrotherapeutic department of every hospital and sanitarium. Recommended for mental cases, circulatory disorders or any treatment where a stimulating massage or mild shock is indicated.

Needle stream sprays of water at any regulated temperature strike the body with an impinging effect, providing a tonic treatment that is extremely salutary where recommended by physicians or surgeons.

Crane hydrotherapeutic showers are sturdily constructed to stand the service expected in hospital use. They are scientifically designed and are in use in many of the country's leading institutions. Now available for relatively prompt delivery. See your Plumbing Contractor or call your nearest Crane Branch.

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CRANE VALVES • FITTINGS • PIPE
PLUMBING • HEATING • PUMPS

NATION-WIDE SERVICE THROUGH BRANCHES, WHOLESALERS and PLUMBING AND HEATING CONTRACTORS

Harvey Agnew, M.D., Editor

The CANADIAN HOSPITAL

Toronto, August, 1948 Vol. 25 No. 8

Obiter Dicta

The Federal Grant for the Training of Personnel

FURTHER examination of the Federal Health Grants is revealing the breadth of study which is expected of the Survey Committees in the respective provinces. These studies are to encompass far more than an analysis of hospital bed needs, important as that is. In the words of the Hon. Paul Martin,

> **"These (Health Survey) grants, totalling $625,000, will make it possible for each Province to establish the planning machinery that will be necessary before it can adequately survey its existing health needs, lay its plans for the expenditure of the National Health Grants, study the extension of its hospital accommodation, and prepare the proper organization of hospital and medical care insurance."**

Probably the most difficult and time consuming task will be that of working out a plan of medical and hospital care, that is, a plan of health insurance, which will be acceptable even to the survey committee, much less some of the bodies which the committee members will represent. But of major importance, too, will be the working out of a program for the utilization of the numerous specific health grants.

Take, for instance, the $500,000 annual grant for "Professional Training". The Council has been informed that one-half of this sum, $250,000 per annum, is to be used specifically for the training of hospital personnel. Both the federal and provincial governments will expect, naturally, that the hospitals will advise them as to how this money could best be spent. Are we prepared to give this advice? It has already been suggested that this money should be allocated for the subsidization of schools of nursing. Subsidies will probably be needed if a modernized type of instruction is to evolve out of the apprenticeship type of training, but a quarter million dollars a year is not enough to provide anything like adequate subsidization of all schools. The amount available would more likely suffice to provide training for instructresses and various types of supervisors, the demand for whom will increase under the new program.

There are other types of hospital personnel, however, for whose training a sizeable portion of this quarter million a year might well be apportioned. Our present schools for laboratory technicians cannot turn out enough technicians to meet increasing demands and some of the fund might be utilized to stimulate more enrolment and more intensified instruction. We need more radiological technicians and here, too, financial assistance would be helpful. Our two schools for medical record librarians cannot possibly supply all the librarians likely to be needed; several more schools would seem to be required. We should have short, intensive institutes for administrators, for accountants, for purchasing agents, for various types of

supervisors, for laundry foremen, for hospital engineers, for hospital dietitians, for hospital pharmacists and others.

The greatest problem is to evolve the machinery to spend this generous sum wisely. It is desirable to have an over-all picture of the types and numbers of hospital personnel whose training should be assisted through this fund. How much of this money will be apportioned to those institutions or organizations undertaking to set up facilities for this training, and how much will be apportioned to the payment of fees and perhaps living bursaries to selected individuals? Specialized training recognizes no provincial boundaries and it would seem desirable to reserve some of this fund for allocation across Canada where it can be most efficiently used in the interests of all provinces.

Revised Benefits and Rates in Ontario Blue Cross

IN July the Plan for Hospital Care in Ontario expanded its benefits and made a modest increase in the rates (see May issue, page 58). The increased coverage to 201 days maximum, the inclusion of care in hospitals for the chronically ill and for the tuberculous, the inclusion of penicillin and other newer drugs, the inclusion of x-ray up to $25, the reduction of the obstetrical waiting period, the removal of the 12-day limit for obstetrical care, and the raising of the age of dependants to eighteen, will be much appreciated by the participants, now well over one million in number. The raising of the rates to 75 cents (standard) and $1 (semi-private) for single persons and to $1.50 and $2.00 for the whole family still leave it unequalled for value received.

What is probably not fully realized by the public is that Blue Cross plans, in paying the "going rate" charged by hospitals, give much more than if a set amount is paid *towards* the hospital bill, as is the customary arrangement with so many casualty companies. To-day with hospital rates going higher every few months to meet rising costs the value of the cash indemnity is becoming steadily less. By adhering to the policy of providing hospital care no matter how high the costs have risen, the Blue Cross plans are giving greater service to the public even though the cost to the plans becomes greater. Since the first of the year the Ontario plan has been eating into its reserves each month to provide for the higher hospital payments. These rose forty per cent since 1942 and very rapidly during the past year. Fortunately, the reserves were sufficient to meet the emergency. The new rates will correct this adverse ratio and will permit the inclusion of the new benefits mentioned above.

There was some opposition to the inclusion of x-ray benefits on the part of spokesmen for the medical profession who contended that the provision of x-ray service was a medical, not a hospital, service. It was finally ruled by the Minister of Health that the subscriber to Blue Cross could be reimbursed up to the amount mentioned, but that the radiologist, when not a full-time member of the hospital staff, might be permitted to charge the patient the amount of his fee for interpretation. A fine point of distinction was involved as to what part of the service is supplied by the hospital and what part by the radiologist. In the vast majority of hospitals the facilities are supplied by the hospital. At any rate it was the contention of the Plan that the financial arrangements are a matter of agreement between the hospital and the radiologist and are not of primary concern to the Plan. The Minister's decision has clarified the situation and the hospitals have been notified that the Plan will pay for diagnostic x-ray services up to a maximum of $25 where the admission is made for illness and not for diagnostic purposes only. The Plan will cover x-ray charges up to $25 where the radiologist is a full-time employee. "Where such is not the case the radiologist has the privilege of charging to the patient the percentage of the total charge to which he is entitled for interpretation of the films. In the latter case the doctor must bill the patient directly for interpretation and the hospital must not include any of the doctor's portion of the charge in the amount submitted to Blue Cross." We anticipate that most part-time radiologists will prefer to have the hospital collect for them.

Oxygen Tent Fatalities

THE death of a patient at Sunnybrook Hospital following a fire in an oxygen tent, due to smoking by the patient, emphasizes again the importance of strict observance of the rules respecting fire hazard. In this instance, there was no suggestion of any laxity on the part of the attendants. "No smoking" signs were well posted and floor polishers and other electrical equipment are not allowed near a tent in use for fear of explosion. All cigarettes and matches are taken from patients about to receive treatment and the supposition in this case is that the matches and cigarettes may have been concealed or smuggled in.

Accidents of this nature will likely occur from time to time despite any precaution taken by the hospital, but other types of mishaps due to faulty equipment or technique do happen. Models with motors should be of approved types only and motors should be kept in good repair. Electric heating pads should be disconnected. Patients should not be rubbed with alcohol or oil. Visitors should be warned about smoking. Greasy material in reducing valves is particularly dangerous. Tents should be of non-inflammable material. So far this equipment has not been subject to any specific C.S.A. standard. However, any electrical attachments would come under provincial electrical codes and, since provincial authorities work closely with the Canadian Standards Association, all electrical parts should meet the fundamental and general requirements of the C.S.A.

Hospitals and Government

Albert V. Whitehall,
Director,
Washington Service Bureau,
American Hospital Association.

THERE are striking similarities between the peoples of Canada and the United States. We suffer the same sorts of illnesses generally, and we treat those illnesses with just about the same drugs and procedures. We have the same kind of hospitals with the same types of instruments and equipment, nurses and doctors, and other personnel—yes, and the administrators of hospitals on both sides of the line have the same sorts of headaches.

There is much similarity in our pattern of government too. We have inherited the Anglo-Saxon tradition of individual freedom, human rights, and the responsibility of government to the desires of the people. We treasure the dignity of the individual and we jealously resist encroachments upon human liberty. The cardinal principle of our society, and it is reflected in both our governments, is total freedom for the individual, consistent, however, with the welfare of the whole community.

Further, we have a very human attitude toward government, and that attitude is found equally on both sides of the line. We each depend on government for an increasing variety of things. How often we see a situation that seems beyond our power to correct. Then we exclaim, "There ought to be a law!" We probably overdo this philosophy because on both sides of the line we pass laws against anything and in favour of everything; our prohibitions and enactments are too often in the area of prejudice. But the fact remains that we are depending on government to do more and more of our so-called "dirty work".

There is perhaps a temptation to turn too much over to government. Sometimes it seems an easy way to dispose of a troublesome problem—let the government look after it. I sometimes wonder if we are doing the right thing about hospital and medical care. In the United States, as I shall tell you later, we are urging that the care of the indigent is the responsibility of government. One reason we do this is because we realize that the burden is far too great to be carried by voluntary charity. Yet there is a monthly magazine in Washington, written by people who are pretty hard-headed practical men, and they write for hard-headed businessmen. In a recent editorial this magazine pointed out that it is cheaper in the long run for business to support voluntary charity than to have government take over the job. In spite of this, and in spite of the fact that many of us realize that government operation is often expensive, we continue to pile more and more responsibility upon government.

To quote John H. Hayes of New York City, president last year of our Association: "The American people think that hospital care is much too expensive and that whatever they can get from government is free and costs nothing."

Yes, we are very willing to have government do things for us. Of course, we reserve the right to scream at high taxes. We recognize that government is taking in taxes much of the money that might come to us in the form of charity. And then we fuss about government waste and expense and bureaucracy. We regard the bureaucrats with suspicion and distaste and sometimes more than that. But let me tell you of a very simple test for bureaucracy. There is one sure distinction between a bureaucrat and a man who is a public servant. If the activity of government in which he is engaged is a project for your benefit, he is a public servant. If you disapprove of his project, he is just a bureaucrat.

State-ism vs. Democracy

Any high school boy can tell you that there are two patterns of government in the world today. One is a pattern which we fear and oppose because it does not recognize the dignity of the individual nor the sacredness of human rights and liberty. Some people call it "state-ism"—the growth of the state at the expense of the individual.

The other pattern is one which we

Taken at the Maritime Convention

Left to right: Mrs. Gladys Porter, Secretary, M.H.A., Dr. J. A. Clark, now Past President, M.H.A., Mr. Albert V. Whitehall, Washington, and Jack L. Bateman, Children's Hospital, Halifax.

Dinner address, Maritime Hospital Association Convention, St. Andrews, N.B., in June.

label "democracy", although usually when we talk about democracy we simply mean that we like the form of government that we have and we want it kept that way. The essential feature of what we call "democracy" is personal freedom consistent with general welfare. Of course, actually neither of these patterns is quite as simple as I have stated.

Admittedly the pattern we call "democracy" is not perfect. We are not foolish enough to claim that it is. We are constantly striving to improve it and that means that we are always finding fault with it. This can be dangerous sport because we are apt to take ourselves too seriously in this fault-finding business. Some of us have already convinced ourselves that everything about our present system is wrong and it all ought to be chucked out of the window. Sometimes the advocates of "statism" provide us with a little sly assistance in this discouraging viewpoint. They make it easy for us to be convinced that what we need is a thorough-going revolution. And then we lose sight of the finest feature of our democracy as we know it. That is the continual process of evolution. The best thing about the system we have is that we can change it as we need to in an orderly manner without upsetting the whole applecart. I repeat that *the finest feature of democracy is its capacity for change.*

Of course democracy is disorderly. Of course it is unpredictable. We need it that way. Where would we be if we could not change?

So, if we in the hospital field are to fit in with the pattern of democracy, we must be able to change our own systems and our own patterns to conform with the needs of the time. We must be able to accept changes gracefully; and we must be careful to preserve those values which are most essential to our continued usefulness in our communities.

Now if we are to adapt ourselves constantly to meet the needs of our changing society, we need more than mere flexibility. We need to have a thorough understanding of ourselves in the first place. Then we must be aware of what is going on around us. And we must have some sort of idea of what the future holds. Does this sound like crystal gazing? There are some guide posts that will help us.

Emphasis on Quality

For instance, there are certain *values* which we must recognize and endeavour to preserve at all costs. No matter what changes we make, we must continue to place our emphasis upon the quality of care. We must continue to try to improve that quality. We must avoid being frozen into any set system which would impede future development. If we ever find ourselves in a position where future improvement is impossible, or where the quality of care is jeopardized, we shall be in danger of failure in our primary duty of providing the best possible care.

In maintaining a high quality of care we must remember that the dignity of man requires treatment of the patient as a *person*, not as a unit or a number. We must remember that one of the fundamental bases of improvement in the quality of care is the humanitarian motivation—the desire to serve mankind. We must somehow manage to preserve the essential human values of medical and hospital care. These human values are the very soul of our profession. Without these values our work is in danger of becoming mechanical, spiritless, and consequently, inferior.

On the other hand, we must avoid undue reverence for the status quo. You remember the Amos and Andy definition for "status quo"? "Status quo", Andy says, "is de Latin for de mess we's in."

Some things need changing. For instance, we definitely need to make hospital and medical care more widely available. There are not enough hospitals; not enough doctors and nurses. We need to develop and expand our health resources so that the high quality of care we now have may be available to every citizen within reasonable cost and convenience. And we need to push back the barriers to knowledge through continued research and scientific exploration. We have made tremendous strides in the greatest war known to mankind—the war against disease—and we must maintain the battle and press on to further and greater victories.

A Three-Point Platform

In 1943 the House of Delegates of the American Hospital Association adopted a three-point platform. First, we said there can be no doubt that more hospitals are needed. At this point, we said, the federal government ought to step in and assist in the construction of additional hospital facilities. You know about the Hill-Burton Hospital Survey and Construction Act which was passed by Congress in 1946. Under the guidance of the Commission on Hospital Care which the Association set up, nearly every state had begun making surveys of its existing hospital facilities and needs. The Hill-Burton Act provided assistance to the states in completing these surveys and in developing state-wide plans which would show the areas where additional hospitals would be most needed. The federal government paid one-third of the cost of survey and planning, and the states paid the other- two-thirds. (In Canada the federal government pays the entire cost of the survey.—Edit.)

Then out of appropriations of 75 million dollars a year for five years, the federal government will pay one-third of the cost of building additional hospital facilities, provided the construction is a necessary part of the state plan based upon these surveys; communities or non-profit organizations may put up the other two-thirds of the cost of construction. That is the first part of our program, adopted by our House of Delegates in 1944, and put into action by our Congress in 1946. The program is somewhat comparable to your own plan.

Our second recommendation was the development of the Blue Cross plans for pre-payment of hospital care. Back in 1944 there were only about 13 million persons protected by Blue Cross; now there are over 30 millions. The medical profession has sponsored pre-payment plans for medical care and these are expanding faster than it is possible to keep up with them. In addition, many commercial insurance companies are entering the field. It is interesting to note that our National Health Assembly, held in Washington during May, gave a vigorous endorsement to the voluntary prepayment plans. There was a great deal of suspicion about this National Health Assembly because our Federal Security Administrator is an outspoken advocate

(Concluded on page 70)

l'Institut du Cancer de Montréal situé à l'Hôpital Notre Dame

L. C. Simard, M.D.,
Chef, la Clinique du Cancer, Hôpital Notre-Dame, Montréal.

L'INSTITUT du Cancer de Montréal, situé à l'hôpital Notre-Dame a obtenu ses lettres patentes de la Province de Québec en septembre 1947. L'Institut a pris naissance en janvier 1942, sous le nom de Centre Anticancéreux de l'hôpital Notre-Dame, et consistait, jusqu'à l'année dernière, en une clinique des tumeurs. Cette clinique fonctionne le mercredi avant-midi de chaque semaine et est dirigée par un exécutif, composé d'un anatomo-pathologiste, L. C. Simard; d'un radiologiste, le docteur Paul Brodeur; d'un médecin, le docteur Roger Dufresne; et d'un chirurgien, le docteur François Archambault. Un groupe de spécialistes, formant un bureau de consultants, assiste l'Exécutif dans le diagnostic et le traitement: L. Gérin-Lajoie, gynécologiste; P. Panneton, oto-rhinolaryngologiste; A. Marin, dermatologiste; D. Marion, obstétricien; R. Amyot, neurologiste; P. Bourgeois, urologiste; J. Tremblay, orthopédiste; R. Dufresne, gastro-entérologiste; A. Guilbeault, pédiatre. Cette clinique du mercredi matin reçoit les cas suspects qui lui sont adressés par les autres cliniques externes de l'hôpital, par les médicins de l'hôpital et par les médicins de l'extérieur. Chaque cas est examiné par les membres de l'Exécutif; puis les examens complémentaires nécessaires, (clinique et laboratoire) radiographies, scopies, biopsies, formules sanguines, sont demandés, et lorsque le diagnostic est posé, un rapport avec recommandations thérapeutiques est adressé au médecin qui nous a présenté le patient. En plus des cas nouveaux, la clinique du mercredi revoit les cas qui sont sous observation et les cancéreux qui ont été traités, ("follow-up"). La clinique du premier mercredi du mois est consacrée aux cancers de la tête et de la peau; le deuxième, aux cancers du sein; le troisième, aux cancers de l'utérus; le quatrième, aux cancers du tube digestif et autres. Chaque patient a un dossier spécial et indépendant du service des archives de l'hôpital. L'Exécutif est assisté par une garde-malade du service social, et par une sécrétaire. Le centre possède ses filières où sont placés les dossiers par ordre numérique, les cartes du service social, les fiches classées par ordre alphabétique et par organe, fiches des biopsies ou d'interventions chirurgicales. Chaque dossier contient un résumé de l'histoire clinique, le résultat des épreuves de laboratoires, la liste des séances de radium et de roentgenthérapie, les constatations des examens périodiques, la feuille du service social, ainsi que la formule de l' "American College of Surgeons" (Abstract Cancer Record Form), avec schémas du cancer et de l'organe intéressée. A chaque examen périodique, une carte spéciale, indiquant l'état du patient, est adressée au médecin qui a recommandé le patient à l'hôpital ou au spécialiste de l'hôpital qui a eu le malade sous ses soins. L'Institut fait installer actuellement un appareil de roentgenthérapie de 400,000 volts. On trouvera ci-après le tableau des cas de cancers examinés, traités et suivis depuis janvier 1942—ainsi que le tableau des nouveaux cas de cancers en 1947.

Les statistiques détaillées des cancers du sein, de l'utérus et du tube digestif font l'objet d'études spéciales; elles seront présentées aux prochaines réunions de sociétés et d'associations médicales.

Depuis janvier 1942 jusqu'à janvier 1948, plus de *deux mille* cancéreux ont été traités et suivis; sur ce nombre, cinq seulement ont été perdus de vue, ce qui rend compte de l'efficacité du service social.

Le nombre de cancéreux a doublé en cinq ans; il était de 223 en 1942, il est passé à 435 en 1947.

Les cancéreux inclus dans la liste de 1942 comprennent *tous* les cas qui ont été examinés, traités ou non, et suivis par notre service social. Ils ne sont donc pas choisis dans le but de flatter la statistique. Plusieurs cancéreux sur ce nombre étaient des cas désespérés très avancés, ayant parfois des métastases généralisées.

Hôpital Notre Dame, Montréal

On ne peut donc juger de l'efficacité des traitements par le pourcentage de survies de cinq ans. Il faut noter cependant que 26% de tous les cas de cancer ou 61 sur 223, vivent encore après cinq ans.

Dans le tableau d'ensemble que doit constituer la lutte anti-cancéreuse, les instituts de cancer, grands centres de dépistage, de diagnostic, de traitement et de recherches, ont tout intérêt a être placés dans des hôpitaux généraux importants. Il s'établit ainsi une symbiose dont l'institut et l'hôpital lui-même retirent les plus grands avantages. Ainsi l'institut profite de l'expérience, des lumières, et de l'action directe des nombreux spécialistes en chirurgie digestive, pulmonaire, plastique, orthopédique, rhino-laryngologique; il profite également des services scientifiques essentiels d'anatomie-pathologique et de radiologie. L'hôpital voit aussi s'étendre son action vers une cancérologie mieux comprise et mieux organisée. Les patients en retirent les plus grands bénéfices, puisque par le travail en équipe, par la spécialisation plus poussée, le dépistage devient plus facile et la thérapeutique, mieux conduite.

Je cite ici un extrait de la conférence de Sir Ernest Rock-Carling, directeur de la lutte anti-cancéreuse en Grande-Bretagne, qu'il prononcait en octobre 1947, à Toronto:

"A word about the 'Cancer Institute'. The balance of opinion with us against the establishment of great central 'cancer institutes' in isolation from the multiple faculty organisation of the general hospitals. If it has not access to all the specialist skill and resources there congregated, it must create a similar team around it, and thus a new 'general hospital' with one disproportionate department —and that, in my experience of hospitals, eventually leads to trouble and sometimes to sterilisation."

Les autorités médicales administratives et médicales de l'hôpital Notre-Dame, constatant qu'il n'existait pas d'unité importante complète, de véritable institut du cancer dans notre province, ont voulu combler cette lacume, et faire leur part dans la lutte anticancéreuse dans la région de Montréal. Les autorités de l'Institut du Cancer de Montréal ont depuis longtemps dressé le plan de leur organisation. Le centre-anticancéreux de diagnostic et de consultation fonctionne depuis six ans. Depuis six ans la collaboration entre les divers spécialistes du centre et les médecins de l'hôpital s'est accrue progressivement. Les consultations sur les traitements sont devenues maintenant pratique journalière. La recherche qui jusqu'à ces dernières années s'intéressait surtout à l'étude des structures des tumeurs, de leur histogénese, des tissus normaux dont elles dérivent, et occasionuellement à l'expérimentation, poursuit maintenant un programme sur l'Institut National du Cancer du Canada subventionne. Un centre de dépistage et de prévention a commencé à fonctionner recemment.

La partie médicale et scientifique de l'Institut sera dès lors complète.

On trouvera ci-après le plan d'ensemble de l'Institut du Cancer de Montréal.

Pour que l'institut atteigne son plein développement il lui faudrait obtenir une centaine de lits pour hospitaliser les cancéreux qui pourraient bénéficier d'un traitement. Nombreux sont les cas qui doivent attendre ou être dirigés ailleurs, faute de place.

Je tiens à remercier ici officiellement le Conseil médical et le Bureau d'Administration de l'Hôpital Notre-Dame qui ont permis l'organisation de l'Institut du Cancer, les membres du Comité de Direction du centre anti-cancéreux qui ont facilité la tache du directeur, les spécialistes du sous-comité, les médecins de l'hôpital qui nous ont accordé leur collaboration et le personnel du sécrétariat dont le dévouement a permis l'expansion de la lutte anti-cancéreuse à l'hôpital Notre-Dame.

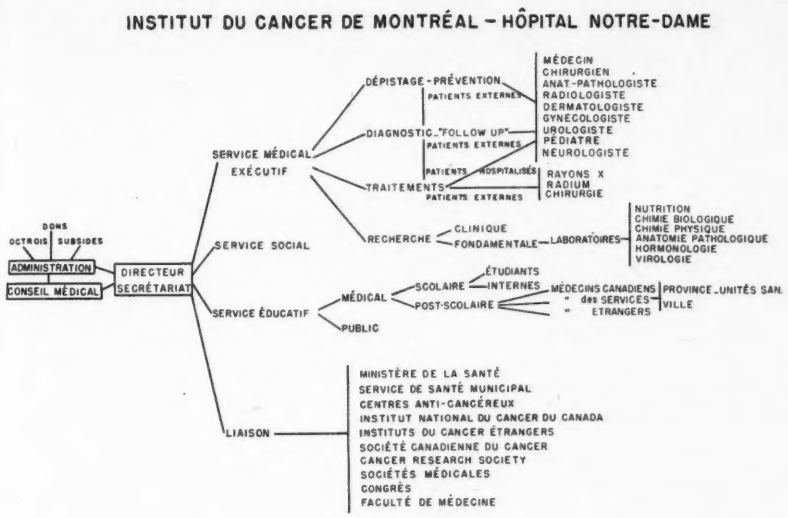
Le Tableau des Cas de Cancer

On trouvera ci-après les cas examinés, traités et suivis depuis janvier 1942—ainsi que les cas en 1947. Les cas sont divisés par organes; la première colonne indique le nombre de cas, la deuxième, le nombre de survies, et la troisième, le pourcentage des survies.

	1942			1947		
	CAS	vivants jan. '48	%	CAS	vivants jan. '48	%
Cerveau	1	0		9	1	11.2
Peau	26	12	45.3	48?1*	46	95.8
Levre	8xx	5	62.5	25?3	24	96
Sinus-Maxillaire	2	0		0	0	
Larynx	6	0		10	7	70
Bronche	0	0		6	1	16.6
Poumon	0	0		2	0	
Bouche	0	0		6	6	100
Langue	6	2	33.3	7	6	87.1
Rhino-Pharynx	1	0		7	4	57.1
Glandes Salivaires	0	0		3	3	100
Amygdale	1	0		2	2	100
Oesophage	2	0		4	3	75
Estomac	14	0		30?2	15	30
Intestin Grele	0	0		1	0	
Colon	11	4	36.3	39?1	24	61.5
Rectum	11	2	18.1	27	20	71.7
Foi	2	0		7	1	
Vesicule	0	0		1	0	
Pancreas	4	0		11?1	0	
Thyroide	2	2		1	0	
Rein	2	1	50	8	4	50
Surrenale	0	0		0	0	
Vessie	3	1	33.3	10	8	80
Prostate	5	1	20	9	8	88.8
Testicele	1	0		3	3	100
Verge	0	0		1	1	
Uterus Col	38	11	28.9	38	36	94.7
Uterus Corps	5x	4	80	20?2	18	90
Ovaires	11	1	9	10?1	5	50
Trompes	0	0		0	0	
Vagin	0	0		0	0	
Vulve	2	1	50	2	2	
Seins	47	9	19.1	47	42	89.3
Ganglions Leugemie	1	0		10	4	40
Ganglions Lymphosarcome	2	0		9?2	5	55.5
Ganglions Hodkin	3	0		8	6	75
Rate	0	0		0	0	
Peritoine	0	0		3	1	
Muscle	2	0		5	3	
Os	2	0		4	3	
Mediastin	1	0		2	2	
Oeil	1	0		1	0	
	223	56	25.7%	435	314	72.1%

***le point d'interrogation dans la première colonne de 1947 signifie le suivant:**

48?1—48 cas diagnostiqués et 1 indécis.



(Resume)

Montreal Cancer Institute

THE Montreal Cancer Institute, located at the Notre-Dame Hospital, was incorporated as such under provincial law in September 1947. The Institute had its inception in January 1942 under the name "le centre anticancéreux de l'hôpital Notre-Dame", and, until last year, consisted of a tumour clinic. It comprises an executive made up of a pathologist, a radiologist, a physician and a surgeon, assisted by a committee of specialists.

The tumour clinic not only receives new cases but also follows those previously treated. A special chart is kept for each patient which is separate from the in-patient and out-patient records.

Two special forms have been drawn up, the first of which represents the cases of 1942 and 1947, classified as to organs, showing the number and percentage of survivals as of January 1948. The 1942 list includes all patients who have been examined, treated, not treated and followed. Many of these were very far advanced cases, sometimes with generalized metastases. The figures given were not chosen specially for statistical purposes. During the past five years more than two thousand patients have been examined and, of this number, only five could not be retraced.

A detailed analysis of the figures relative to cancers of the breast, cervix and digestive tract will be presented to the Medical Societies in the near future.

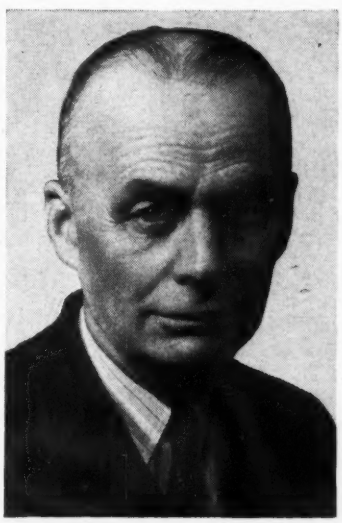
The second form represents the actual organization of the Institute. The cancer detection and prevention centre has been inaugurated this year.

Dr. F. W. Jackson Appointed Director of Health Insurance Studies

Dr. F. W. Jackson of Winnipeg, who for the past 17 years has been deputy minister of health for Manitoba, has been appointed to the newly created post of director of health insurance studies. He will guide the new $150,000,000 federal health program and prepare the ground for national health insurance in Canada.

Besides a long and distinguished record in public health work, Dr. Jackson has been professor of preventive medicine at the University of Manitoba since 1939 and for several years has given special lectures at the School of Hygiene, University of Toronto. Born at Stonewall, Manitoba, he was graduated from the University of Manitoba medical school in 1912. In 1929 he received his diploma in public health from the University of Toronto. During World War I he served with the C.E.F. in Salonika, Greece and England.

In announcing Dr. Jackson's appointment, the Hon. Paul Martin said: "We are deeply grateful to Premier Garson and to the Hon. Ivan Schultz, Manitoba's minister of health and public welfare, for their co-operation in making Dr. Jackson's services available to the federal government."



F. W. Jackson, M.D.

Correction

On trouve dans l'issue de julliet de ce journal un article que s'appelle "L'Hôpital Saint François d'Assise" et qu'était preparé pour ces colonnes à la suggestion de St. Ste. Gertrude, Supérieure de l'Hôpital Civique à Québec. A cause d'une conception erronée, le nom de Sr. Ste. Gertrude est apparu, tandis que Sr. Ste. François Joseph des Soeurs de St. François d'Assise a écrit la texte et a fourni les illustrations. On regrette si fort cette méprise.

Change of Address
Canadian Dietetic Association

Last month the headquarters of the Canadian Dietetic Association was moved from 78 Grosvenor Street, Toronto, to 238 Bloor Street West in the same city. Any correspondence addressed to individual members of the Board of Directors or Executive officers of this Association via the new office should have the name of the Association on the envelope.

National Health Proposals Imply

Increased Responsibility for HOSPITAL TRUSTEES

D. F. W. Porter, M.D.,
Director, Hospital Services for New Brunswick, Fredericton.

FROM time immemorial, communities have been blessed with persons who "went about doing good". These people of generous heart have been directly responsible for the social reforms which today play such a great part in our every-day life. In spite of the fact that government bodies at all levels have assumed ever-increasing responsibility for measures of social welfare, interested voluntary groups will continue to be necessary to assist in public education, to act as advisers to government bodies, and to act as well-intentioned pressure groups to obtain government assistance and action.

The hospital trustee is a member of a voluntary group, one of the duties of which is stimulating public interest in the sphere of hospital care. He or she is also a member of a governing board legally charged with the responsibility of *providing* and *maintaining* hospital facilities in a given area. The standard of hospital care in your community depends directly on the choice of the trustees who fill this dual role, and almost as directly on the effort made to enable the newly-appointed trustee to "grasp the vision" as speedily as possible. Institutes for hospital trustees are a step in the right direction and should be further developed. The publication *Trustee* has filled a long-felt need and this magazine should be carefully studied by all members of hospital governing boards.

The recent implementation of health grants by our federal government ushers in a new era for the health of our people and is the first step towards attaining that ideal in carefully planned stages. The trustees of existing hospitals and those yet to be built will require greater familiarity with hospital affairs, more elasticity of mind, and a newer concept of hospital financing, if their hospitals are to be properly fitted into the overall picture.

It is quite apparent that the federal government proposes to leave the planning for and administration of the new health grants as a distinctly provincial responsibility, and will maintain at federal level only a "benevolent watching eye" on the entire proceedings; although in the words of the Hon. Paul Martin, Minister of National Health and Welfare, "all that is being done constitutes the essential first stages in the development of a comprehensive national plan . . . for hospital and medical care insurance."

Because of the absolute urgency of providing sufficient hospital beds in every province in the shortest possible time, I particularly wish to stress the responsibility of hospital trustees to their respective communities from this day onward. My statements are to be taken as my own personal views, and not necessarily those of my Department or of the Government of this Province.

The day of the truly "private" hospital is approaching its eventide. The personal wishes and ambitions of one or two persons cannot provide the community with adequate and democratic hospital care. The responsibility for providing this care must, of necessity, be vested in a representative governing board. In this regard, would it not be better if our Religious hospitals had governing boards truly representative of their community life? It is very much to the credit of the Councils of Sisters that they have been able to carry the load alone in their respective hospitals in such a competent manner in the past; but one has ventured to suggest to them in recent weeks that it might be desirable to consider a revision of their policy with respect to their governing boards. It is my sincere hope that the Sisters can and will provide for this very urgent need; for the spirit of service, which is inherent in the lives of the Sisters, must be maintained and expanded in the hospitals of our province.

Provision of Facilities

In the matter of providing adequate hospital accommodation, the trustee today has two very urgent responsibilities to the community. These can be casually classed under two groups as follows:

1. Long-Term Planning. It is estimated that three to five years will elapse before the provinces will have completed the new hospital construction needed today to make up our very gross deficiencies. It appears imperative, therefore, that close liaison with Provincial Departments of Health will be necessary so that plans for individual hospitals will be properly fitted into a well-balanced and integrated hospital system for each province.

The new federal health grants provide for capital to be made available for the construction of hospitals, on condition that the provinces match the required amounts at least dollar for dollar. It seems reasonable to assume that the allotment of this new capital from dual sources might best be made by a representative provincial body modelled somewhat along the lines of our New

Excerpt from an address presented at the M.H.A. meeting in St. Andrews N.B.

Brunswick Hospital Planning Committee. It further seems reasonable to assume that the overall provincial need for hospital beds will necessitate more small rural hospitals and that duplication of hospital services in the larger urban centres will be discouraged.

Professional and administrative staffs of larger hospitals should be in a position to provide various consulting services to the small hospitals in their general areas. Careful attention should be paid, also, to the very great health benefits derived by the community in those areas where hospitals have been developed into true community health centres.

Finally, all plans for expansion and new construction must be so elastic as to allow for further expansion, at a later date, to meet the increased demand for beds which *will* come when health insurance is finally implemented.

2. Planning for the Interim. Approximately 16 per cent of the beds in New Brunswick general hospitals were occupied by chronics in 1947. Furthermore, our general hospitals, in the same year, had waiting lists reaching as high as 40 per cent of their normal bed capacity. Hospital trustees must decide whether the community need can best be served by retaining the chronics or by releasing these beds to those requiring active treatment. Remember that by proper utilization of hospital beds in accordance with present standards, 36 patients per year should be accommodated per bed.

This problem of providing hospital care for the chronically ill, convalescent, and the aged infirm, is not a passing one and we might as well face the fact that the number of such cases will increase rather than diminish. One ventures to suggest to hospital trustees that a very fair percentage of the chronic cases now in hospital can be taken care of in the private homes of immediate relatives, no small number of whom have the necessary housing accommodation and are financially able to provide adequate care. There appears to be no rational excuse for this class of chronics to be retained in our active treatment hospitals. For the rather larger group of indigent chronics, hospital trustees must undertake to provide workable compromises in their individual communities during the next year or two.

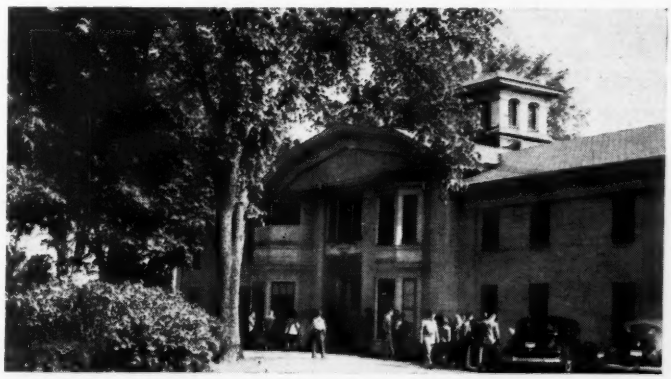
It is suggested that we cease to delude ourselves with the thought that hospital costs will come down but rather prepare for a considerably higher scale. On the other hand, it is suggested that hospital trustees can provide the public with more service per dollar of cost. A very considerable proportion of present basic hospital costs are a direct result of faulty long-term planning. One of the most pernicious faults in planning has been the parsimonious attitude of governing boards towards

(Concluded on page 84)

At the Maratime Convention,
St. Andrews-by-the-Sea

Delegates gathered on the wide veranda of the Algonquin Hotel when Dr. O. C. McIntosh of Antigonish gave an address of welcome to suppliers' representatives and the President formally declared the exhibits open.

Left to right: Miss Mary Ingham, Woodstock, N.B., Mr. J. D. Winslow, Woodstock, Miss R. E. Fallis, St. Stephen, N.B., and J. T. Bentham, Hygiene Products Limited.



A feature of the convention was a drive to the Chipman Memorial Hospital at St. Stephen.

The Control of LINEN

How Sunnybrook Hospital Handles This Problem

H. E. LeMasurier,
Business Manager,
Sunnybrook Hospital, Toronto.

THE method of laundry and linen control described here is that which has been instituted at Sunnybrook Hospital. It should be made quite clear that this system is designed (a) for a Department of Veterans Affairs Hospital, and (b) to provide an adequate system for a hospital organization that involves almost entirely military personnel on both staff and patient strength.

The reasons for these two qualifying remarks are most obvious, as everyone knows that stealing Government property in the army never happens, but to borrow or "scrounge", whether on a short term or permanent basis, is regarded as a soldier's privilege. His ability to do this to a great extent determines his standing in his unit! In any case, extreme conditions require extreme controls; consequently, it is felt that the system to be described will work quite well on a civilian basis, as it is not considered that the civilian mind has anything to contribute to the soldier's "bag of tricks" for borrowing or scrounging linen.

Clean Linen Control

The custody and distribution of clean linen is the responsibility of the staff of the central linen room of the hospital. From this clean linen room all linen supplies are secured and all reserve stocks properly stored. This room should be adequate in size, containing open slatted shelves, with a small counter across the door to prevent access to these shelves. The clean linen is stacked in accordance with a standard stacking schedule. For instance, ten might be the accepted number by which to pile sheets, ten pillow cases, five pyjama jackets, et cetera. This enables easy checking of inventory and allows speedy issues. The stock of this room is shown on an Inventory Sheet, and is not subject to change, except by high authority.

When issues to wards or nursing stations are made, the linen in question is taken and deposited in a linen closet suitably located on each ward or station. The issue is based on the type of activity to be carried on and the entire issue listed on an inventory board which is retained in the linen closet. This is regarded as a permanent level of stock. The charge nurse is responsible for this stock and from this stock the distribution to the ward is made to meet requirements. When the charge nurse issues linen to a patient, all items are listed on a linen card, which is signed by the individual concerned. This card remains on file in the charge nurse's office until the patient is discharged.

Soiled Linen

Similar to the central linen room, and in close proximity to it, is a soiled linen room, which contains open bins for sorting the various soiled items. All soiled linen passes through this room before despatch to the laundry. When a man is ready for discharge, he returns to the charge nurse all soiled or clean linen items which are listed on his linen card. The nurse acknowledges receipt of these items on the linen card and this card is forwarded to the Discharge Office before discharge documentation can be completed. The soiled linen received is placed in a soiled linen closet on the ward or nursing station. The same key which is used for the clean linen closet is used for this closet also. No other key will open either of these two closets.

H. E. LeMasurier

Every morning a linen store representative calls at the various soiled linen closets in the hospital and, in conjunction with the charge nurse or her delegate, counts and bundles the soiled linen in accordance with a "bundling schedule". Examples of this "bundling schedule" are as follows: 19 sheets wrapped in one, making 20; 9 aprons wrapped in one, making 10; 4 orderlies' trousers wrapped in one, making 5. Quantities for bundling of each item are detailed on the aforementioned schedule. This obviates the use of tags. Only bundles not containing the scheduled amounts are tagged.

At this time the linen stores representative prepares a receipt in triplicate. One copy remains with the charge sister, one is forwarded to the central linen room, and the third copy accompanies the shipment to the soiled linen room and then to the laundry. In some cases the soiled linen closets have laundry chutes where the bundles are sent to the basement level for collection, but in cases where chutes do not exist the bundles are collected in large box trucks.

Clean Linen for Soiled

This brings us to the distribution of clean linen in return for receipts of soiled linen. When the central linen room receives the second copy of the aforementioned receipt, they immediately assemble the quantity shown and this is taken by truck to the linen closet concerned in order to bring it back to a level of stock shown on its inventory board. At the end of each day a recapitulation is

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From an address presented at the Ontario Institute for Hospital Administrators at London in April.

John H. Fisher,
M.D., M.Sc., F.R.C.P. (C)
London, Ontario.

The Clinical Laboratory in the General Hospital

IT has been said that the clinical laboratory is "the heart of the hospital". Certainly it is generally conceded that clinical pathological services are essential in the diagnosis and treatment of disease and in its prevention and control. I use the term "clinical pathology" in a broad sense to include tissue examination, clinical bacteriology, clinical chemistry, haematology, serology, and other laboratory procedures which have a particular clinical application. "A clinical pathologist" should be looked upon as a consulting physician who is not only able to conduct the laboratory investigation but is also willing, and available, to assist and guide the attending physician in the interpretation of results and in the clinical management of his patient.

Laboratory investigations of clinical patients are almost without number. In some patients a wide range of laboratory tests may be indicated and even by employing these it may not be possible to arrive at an accurate diagnosis. In others, a few relatively simple procedures may be sufficient. There are sound reasons for employing routinely a well chosen but small group of laboratory tests to supplement the physical examination of the patient. Such a practice permits a higher percentage of correct diagnoses upon the initial survey of the patient. For economic and other reasons it is highly desirable to make an accurate diagnosis and to institute appropriate treatment as promptly as possible. Accurate diagnosis is essential for specific treatment which is always more to be desired than purely symptomatic treatment. Some tests are pathognomonic, some are supplementary, others are necessary for the control of treatment and still others are required to determine the proper release of the patient.

Certain routine laboratory procedures may well be done in the doctor's office. In this group I would mention urinalysis, sedimentation rate, haemoglobin estimation, collection of blood for serological tests for syphilis, occult blood in the stools, and collection of blood samples for certain blood chemistry estimations. Other tests must be referred to the clinical laboratory but can be satisfactorily carried out on the ambulatory out-patient. Still others require more elaborate preparation and hospitalization of the patient for a varying period of time.

As hospital administrators it is your responsibility to see that adequate laboratory facilities are provided for the proper care of your hospital patient. A clinical laboratory is an absolute necessity.

"The advantages of a resident service over *mail order* pathology cannot be over-emphasized."

How is this to be accomplished?

In the *large* hospital it is not such a difficult problem. The clinical laboratory should be a separate department under the supervision of a capable director of laboratory services. The director should be a medical graduate, well trained in clinical pathology and preferably certificated as a specialist in his particular field. He should be provided with good equipment and an adequate technical staff to take care of the volume and the type of work he is called upon to do. Unfortunately few such men are available at present. From senior matriculation it requires at least eleven years before a person could qualify for such a specialty. The long period of training, the relatively few good opportunities, and the inadequate remuneration for pathologists in Canada, have seriously handicapped the output of men qualified in this field. Many promising well-trained young pathologists have been lured to the United States by salaries two and three times those commonly paid here for this type of work.

The right type of clinical pathologist can be a tremendous asset to any group in medical practice. As Inglis has said so aptly: "A well-trained pathologist endowed with the true scientific spirit, one who can win the confidence of his clinical brethren, will prove to be a boon to any group of practitioners. In competition with none, he can, in his special field, be adviser to them all. If he is of the right calibre he will bring an interest into their work such as they never dreamed of, and, should there be some who feel overburdened with monotonous routine, he may save them from becoming mere carpenters and pillmongers of the profession. To do all this a man must be endowed with high qualities and that is why those who are devoted to pathology hope to attract to its ranks the very best of our graduates."

For the *small* hospital, perhaps of 25, 50 or 75 beds, and the *medium-sized* hospital, say from 100 to 250 beds, too small to provide themselves with the services of a full-time resident pathologist, the problem of providing adequate laboratory services is more difficult. Such hospitals should set aside adequate space for laboratory accommodation, should provide good laboratory equipment

An address presented at the Ontario Institute for Hospital Administrators, London, in April.

and employ well-trained technicians. The work of the laboratory must be supervised by a clinical pathologist. In the small hospital there would be insufficient work to employ a pathologist full time and the hospital would not be able to support him financially. Under these circumstances one pathologist might serve more than one hospital (perhaps as many as three small neighbouring hospitals) by establishing headquarters in one of them and by making regular visits to the others.

I must emphatically decry the practice of appointing a medical practitioner as director of laboratories. Usually he is too busy with his practice to devote the proper time to the laboratory. He is insufficiently trained in laboratory procedures to be thoroughly conversant with laboratory methods. For these reasons it is obvious that such a plan fails to elevate the calibre of the laboratory work. I must also strenuously oppose the combining of radiology and clinical pathology under a common director, for such an appointment would attract neither a well-trained radiologist nor a first class pathologist.

Why is it so important to establish resident laboratory services for your hospitals?

The advantages of a resident service over "mail order" pathology cannot be over-emphasized. Promptness in diagnosis is one of the major advantages. With a laboratory service within your hospital it may be possible to get a diagnosis in a few minutes or at least in a few hours, whereas by mail it may require several days to a week. By that time the patient may be dead, or have recovered. Think of the advantages in cancer diagnosis where radium is being employed, or the advantages of rapid frozen section diagnosis in the operating room by means of which the surgeon may decide, on the spot, whether a simple or a radical operation is indicated. Close contact between the pathologist, patient, and clinician, is most desirable. It affords an opportunity for consultation concerning diagnosis, treatment and management of the patient, which consultation would be very unsatisfactory at a distance. Think also of the many contributions the pathologist can make, at the meetings of the attending staff of the hospital, in the interpretation of laboratory investigations and in the presentation of postmortem findings.

An active autopsy service is most necessary for obvious reasons. It raises the standard of medical practice. It is a check upon clinical diagnosis and x-ray findings and it establishes the cause of death. So often, particularly in the rural communities and where the services of a pathologist are not available, the autopsy is undertaken by a clinician. Only too frequently, he is too busy to make an adequate investigation, or he is insufficiently trained in pathology to appreciate what he does see and to conduct an intelligent and systematic autopsy. He probably will remove a few organs, parts of organs or pieces of tissue, submit them to a pathologist and expect a complete report upon the case. The net result of all that effort is, at the best, a very incomplete and unsatisfactory autopsy investigation which advances our knowledge little, if at all, and casts serious reflections upon the importance of autopsies.

What are the difficulties in establishing adequate laboratory services?

Adequately trained pathologists are in short supply at present. Far be it from me to look at the situation from a purely commercial or remunerative viewpoint, but the economic aspect concerns the future supply of pathologists. Salaries paid to pathologists in general have not been sufficiently high to attract anything like sufficient numbers of promising young men into this field of medicine. Clinical fields look greener and the specialty of radiology is a ripe plum ready to be picked by the enterprising young medico. I am willing to grant that, in pathology, there are certain compensations for the low salary but, nevertheless, the salaries frequently paid are not commensurate with the importance of the work, the incumbent responsibilities, and the long and arduous training. The Provincial Laboratories and the Canadian Red Cross Society have invaded the field of laboratory medicine. They are carrying out laboratory procedures, free of charge or for a very nominal fee, far beyond the field of public health.

Another difficulty is the *scarcity of trained laboratory technicians.* Some time ago, a report to the Honourable The Minister of Health for Ontario from the Laboratory Diagnostic Services Committee, recommended that, in order to provide better laboratory services within hospitals, four classes of technicians should be trained, namely:

Class A—those having completed a four year university course in laboratory technology;

Class B—those having completed one year's advanced practical training in a supervised diagnostic laboratory, having previously fulfilled the requirements of Class C;

Class C—those fulfilling the requirements of the Canadian Society of Laboratory Technologists;

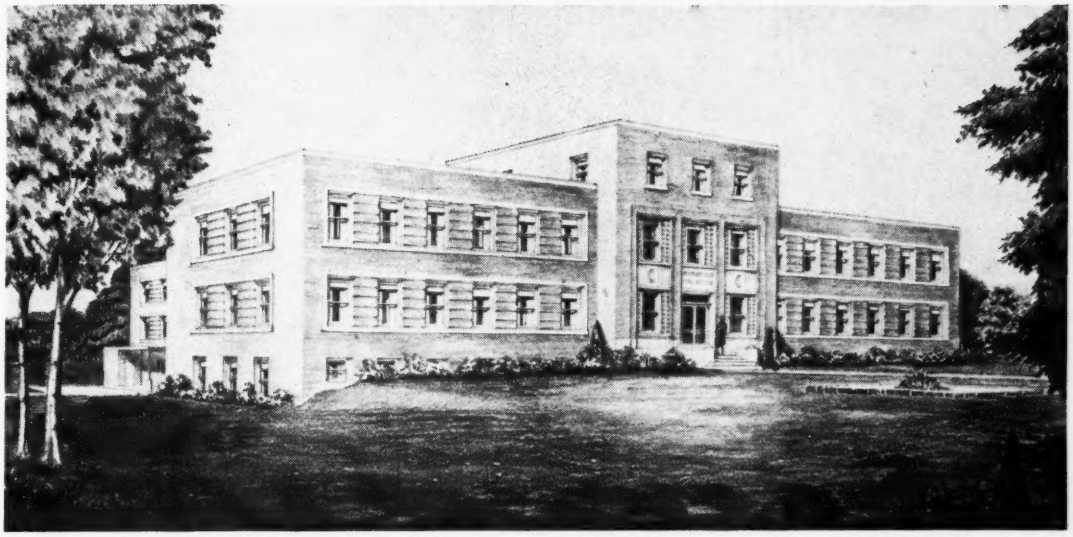
Class D—those staff nurses of a small hospital who have completed a prescribed short course of training in laboratory procedures in a recognized laboratory.

A good number of first class training schools for Class C technicians are being conducted in our larger hospitals. More are needed. The laboratory career of the average female technician is often relatively short. Many succumb to marriage after a short period of laboratory service and thus are removed from that field of endeavour. The University of Western Ontario has inaugurated a three year course from senior matriculation leading to the degree of Bachelor of Science in Laboratory Technology. The first year is spent in a science course at the College of Arts and the two following years are devoted to practical training in our diagnostic hospital laboratories, on a rotating service divided between tissue pathology, clinical chemistry, haematology, clinical bacteriology and serology. During these two years lecture demonstrations are given in anatomy, physiology, biochemistry, histology, and bacteriology.

No matter how capable technicians are, they are not diagnosticians and they are not directors of laboratories. The director of laboratory services must be a medical graduate, preferably a pathologist, upon whose shoulders rest all the responsibilities of the laboratory and their implications.

A third difficulty is that some hos-

(Concluded on page 72)



A New 51-Bed Hospital
to Serve Leamington District

Harold J. Smith,
M.R.A.I.C.
Architect, Toronto.

EARLY this spring construction was begun on the new general hospital which will serve the town of Leamington, Ont., and surrounding districts. It is to be known as Leamington District Memorial Hospital. The site chosen is approximately four acres in size, is on one of the highest levels in the community, and is bounded on three sides by residential streets.

When finished the building will comprise a complete general hospital. three storeys high. The dietary department, boiler room, laundry and storage rooms are on the ground floor. (See next page). On the first floor are the administration offices, surgical suite, x-ray rooms, and public wards including accommodation for seven children in a separate department. Owing to the slope of the ground and through additional grading, it is possible to have general supplies delivered on the ground floor at the east side of the hospital while the ambulance entrance on the west side is at first floor level.

The maternity department, including an obstetrical suite and creche, is on the second floor of the north wing while the same floor, south wing, contains private and semi-private rooms for medical and surgical cases.

There is a third floor over the central portion only. Most of this space is being used to provide four light and airy private rooms for nurses, together with a common living room. One section has been set aside for ventilation equipment and elevator machinery.

Bed accommodation in the new hospital has been divided as follows:

Adult beds	44
Children	7
Creche	16 cubicles
Suspect creche	2 cubicles
Nurses' bedrooms	4

The building is of fire-resistant construction, the interior frame-work being of reinforced concrete. The exterior is almost entirely finished in a buff pressed brick since funds were not available for the use of purely decorative cut stone. The general design, as illustrated above, features modern simplicity.

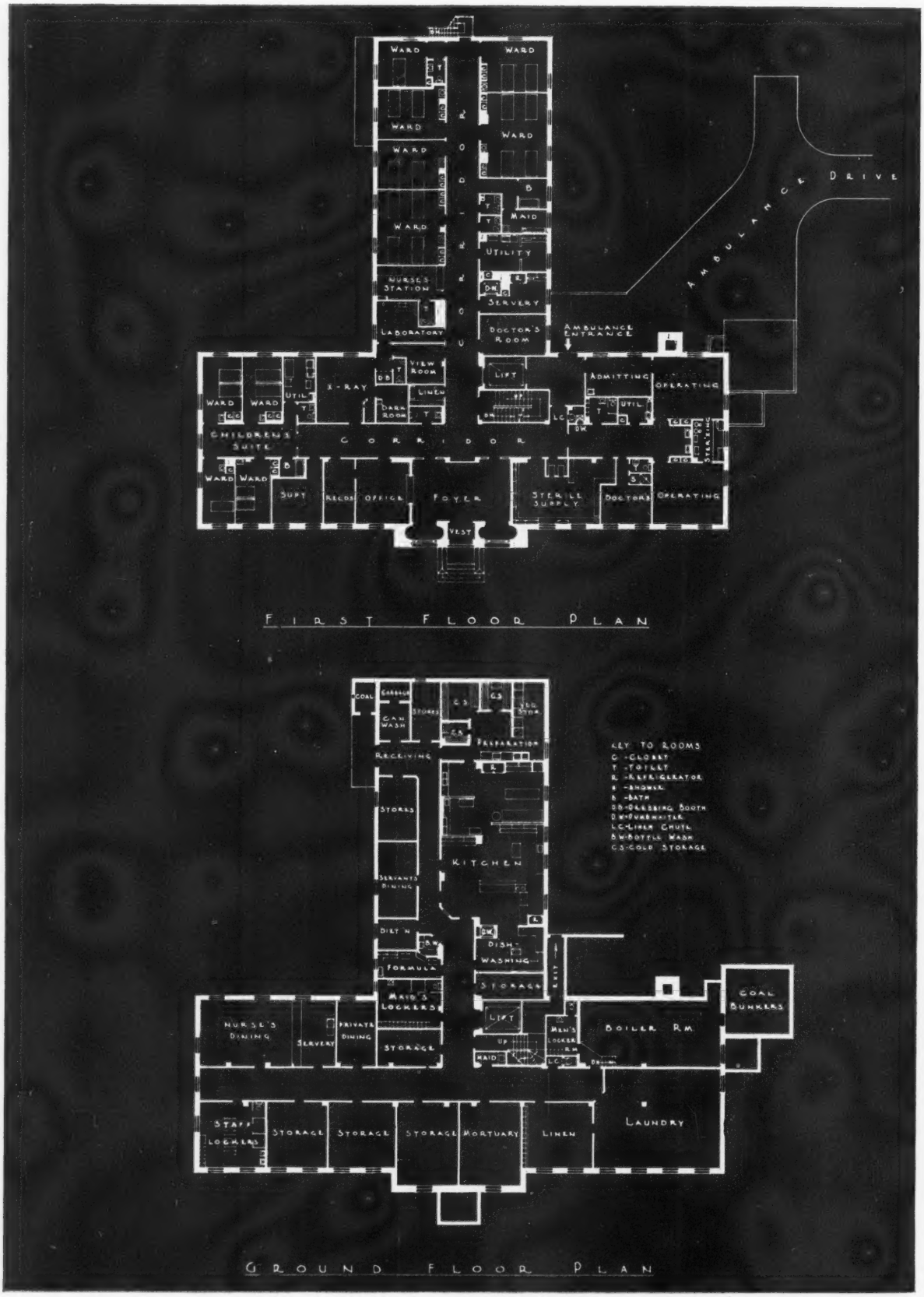
In finishing the interior, it will be necessary for the sake of economy to use painted plaster on practically all walls. However, ample use will be made of acoustic materials in order to help deaden sound reverberations. Service room floors are of terrazzo. Offices and dining rooms are to have floors of mastic tile while all wards and corridors on the first and second floors will have linoleum floor finish.

All service rooms will have ample ventilation as three separate systems are being installed for this purpose. Still other systems will provide fresh humidified air for the surgical and obstetrical departments.

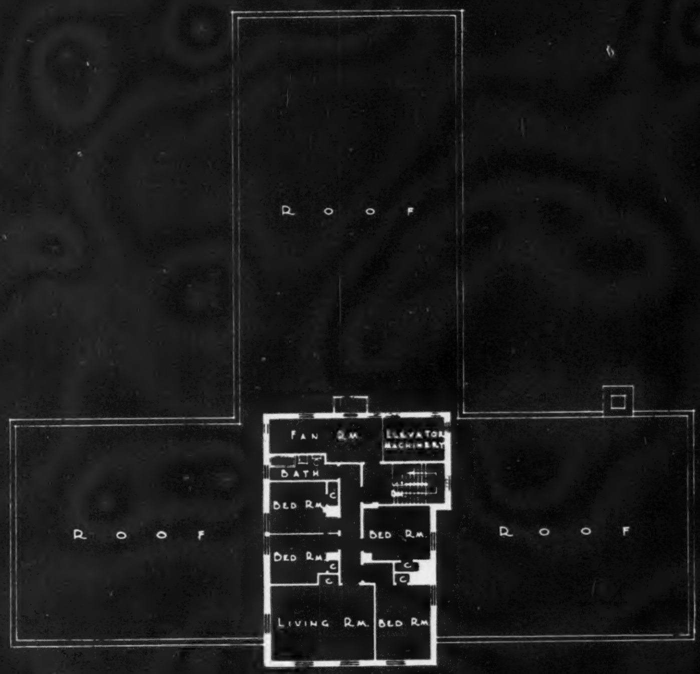
The building has a cubic content of 353,000 cubic feet and this works out to 6,920 cubic feet per patient bed. In arriving at this latter figure, only adult and children's beds were included.

On the basis of the two floors which provide patient accommodation, together with the necessary treatment and service rooms as well as surgical and obstetric suites, the building area works out to 360 square feet for each patient bed. Again this figure does not include creche cots.

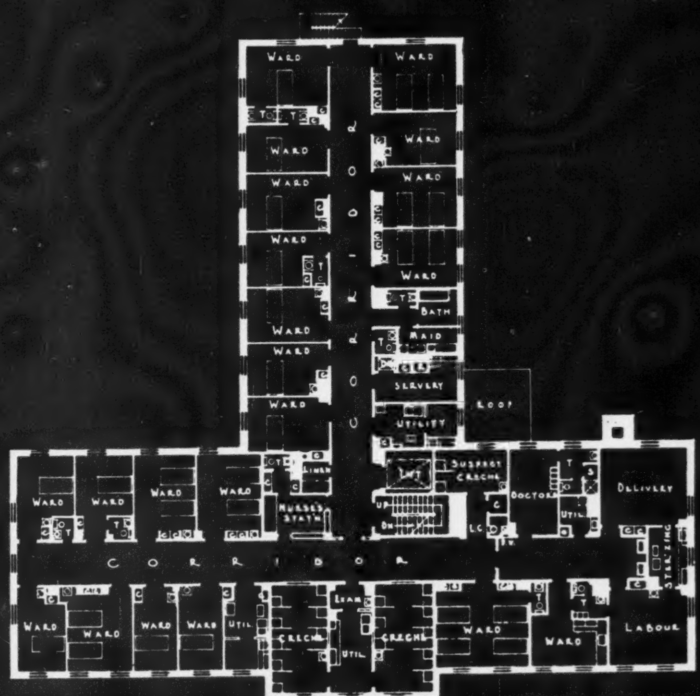
The cost of this new hospital, not including architect's and engineer's fees and furnishings, is now estimated at approximately $400,000.00.



Leamington District Memorial Hospital



THIRD FLOOR PLAN



SECOND FLOOR PLAN

General Practitioners and Hospitals

Harvey Agnew, M.D.

THE growing concern of the general practitioners with respect to their hospital privileges would seem to have been a major reason for the passing of a resolution at the recent Canadian Medical Association Convention urging the setting up of a general practitioners' section within the Association. This action was taken at a special meeting for general practitioners and is parallel to the steps taken in the United States when, in 1945, a General Practitioners' Section was set up in the American Medical Association.

It has been obvious for several years that, sooner or later, this situation would need clarification. So far it has not affected the practitioners in smaller centres to any degree, for the usual arrangement is to have practically all of the doctors in the area on the hospital staff. Frequently doctors in villages or towns some miles away are placed on the courtesy rather than the active staff, but few established general practitioners in rural regions are denied paying patient privileges in the local public hospital unless there is some good reason for so doing.

In urban areas, however, the picture frequently is different. As medical diagnosis and treatment becomes more intricate, and as an increasing number of physicians specialize in the various fields of medicine, the tendency has been to place these highly trained specialists in charge of the different services. In teaching hospitals and some others the tendency has been to fill the other appointments with specialists also. The development of "certification" for specialists by the Royal College of Physicians and Surgeons, a long overdue development, has made it possible for many hospital staffs to require that all heads of services be certified and, again, many of our teaching and other highly departmentalized hospitals insist that *all* members of their active staffs be certified or be working towards that objective.

This trend has been evident for a longer time in the United States where specialty boards existed some years before certification began in Canada (i.e., except in Alberta where specialists have been certified for many years). Many American hospitals now limit their staffs to diplomates of the various boards.

General Practitioners Protest

That general practitioners in the larger centres would protest this discrimination is obvious. Without the facilities provided by the hospital, it is exceedingly difficult for the general practitioner to give his patients the best that is now available in diagnosis and treatment. Many procedures cannot be carried out other than in the hospital. Either the general practitioner turns his patient over to someone with hospital privileges, as has been the practice in Germany for many years, or he does one of two things. Either he treats the patient at home or at the office, using what limited facilities are available, or else he takes the patient to a small proprietary (private) hospital where, all too often, facilities are inadequate and the organized staff control and supervision, if any, none too effective.

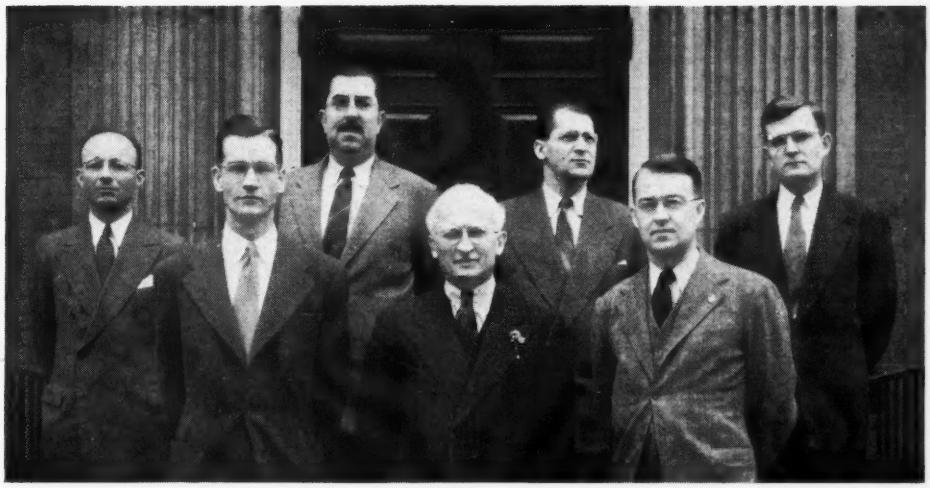
The increasing use of hospital facilities for obstetrics is making it difficult for many general practitioners in cities to continue this important feature of general practice, except in nursing homes. In some larger hospitals, general practitioners can utilize the private wards for obstetrics although not eligible for the public maternity wards; in others, the list of general practitioners able to get beds on the private wards has been definitely limited. The provision of free hospital accommodation in Alberta for obstetrical patients a few years ago, a popular measure which might well be taken up in other provinces, has emphasized the importance of hospital privileges to the general practitioner, who sees no reason why even normal obstetrics should be taken over by the specialist with access to beds. With prepaid government hospitalization in Saskatchewan, and with Blue Cross supplying hospitalization in other provinces, it can but be expected that some hospital connection will become increasingly imperative if the general practitioner is to retain what he considers to be his legitimate field of practice.

Trustees who must approve, or disapprove, restricting policies on the part of their medical staffs are somewhat on the horns of a dilemma. Their natural pride in their institutions makes them sympathetic towards a policy of high staff qualification which they realize would make the hospital stand out as a centre of medical attainment. At the same time they do seem to realize the serious predicament of the general practitioner in the community. What may not be fully recognized is that, while a restricted staff may improve the quality of care *within* the hospital, the forcing of many practitioners to work elsewhere, not to mention robbing them of the inspiration and stimulus of working with the leaders in the profession, may result in an actual lowering of the quality of medical care for the community as a whole.

The situation would seem more acute in American cities than it is here; at least, it has been a matter of hot debate for several years. In at least one city a separate medical society for general practitioners has been set up; it is pleasing to note that there is no thought of setting up a separate national association here and, as far as we know, no local society. In one American city a movement is on foot to take over completely one large hospital as a general practitioners' hospital.

Two Suggestions

As an alternative to such a step here—and one can see some grave problems that would arise—two suggestions have been made by students of the subject. One is that a number of general practitioners be appointed to the medical, obstetrical, surgical, paediatric, and perhaps other departments to work with the specialists in those fields. This has



Initial Class in Hospital Administration

University of Toronto

The initial class of the 21-months course in hospital administration at the University of Toronto has now completed the nine months period on the campus and has been assigned to administrative internships. Starting in September a new class of ten has been enrolled.

Back Row; Dr. Benjamin G. Rothman (now in Denver, Col.); Dr. Geo. W. Peacock (now in Kingston); Walter J. Birch (now in Toronto); H. Robt. Cathcart (now in Grand Rapids, Mich.).

Front Row: Wm. B. S. Trimble, M.A. (Fellow); Dr. Harvey Agnew; Dr. Leonard O. Bradley.

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some merit and would be a grand thing for the general practitioners so selected, as well as for the students should the hospital be connected with a medical school. The benefits, however, would be limited to but a comparatively few men and would still not solve the problem of the general practitioners not so recognized.

The other possibility is that there be set up in the larger hospitals a *general practitioners' service, staffed and controlled by general practitioners.* This service would cover the different major fields of medicine and be under rigid controls by a responsible committee to determine the point at which the care of the patient becomes the responsibility of the specialist.

The latter alternative would seem to be a more practicable suggestion. Actual experience with this plan at the 450-bed Mount Carmel Mercy Hospital in Detroit was reported in May of last year.* Here a general practitioner division has functioned for some years with notable satisfaction. Rigid rules are followed and the division studies and appraises its own cases. Consultations are frequent and the specialists are prepared to "stand by" or merely to advise if it is a case which the general practitioner is well qualified to handle. It would seem that the supervisory committee of general practitioners deals with an iron hand in protecting the public against incompetent or overly ambitious practitioners and the relations with the specialists on the other services in the hospital are very cordial. An example like this is better than endless theorizing.

*J.A.M.A. 134: 1 May 3, 1947. P. 15.

Improved Rural Practice

While this question of hospital privileges would appeal to the urban general practitioner as a major reason for forming a General Practitioners' Section in the Canadian Medical Association, rural physisians have other problems which they would like such a section to consider. These would probably include rural nursing, rural public health, diagnostic services, outpost nursing station and other small hospital facilities, the provision of diagnostic facilities, refresher courses, medical economics and other topics.

The idea of a certificate for the qualified general practitioner is certainly gaining ground. Although, at first thought, the idea seems illogical, it would warrant serious consideration. The better general practitioners with two or more years of internship, repeated refresher courses, and years of successful experience behind them, do resent having everybody who is not a specialist dumped into one can and labelled "the others". They point out—and with reason—that there are many grades of general practitioners and that those who are well qualified and have demonstrated their ability should be given recognition just as in the case of specialists.

There is a strong feeling, too, that there would not be such a disproportionate number of recent graduates rushing into specialties if the students had a better knowledge of what constitutes general practice. To this end a general practitioner service in teaching general hospitals would be of some advantage, for in many schools we doubt if the medical students ever meet a general practitioner, unless, perhaps, when home on their holidays.

Nursing Service is Changing

Lucy D. Germain, Reg.N.,
Director, School of Nursing and Nursing Service, Harper Hospital, Detroit.

CURRENT changes in nursing service have their genesis both in nursing and in related fields. They include (1) advances of medical science; (2) hospital administrative practices; (3) expanded health programs on local, state and national levels, which create more opportunities for nurses; (4) the economic situation; and (5) the improvement of personnel practices for nurses along the line of those practised in other fields of endeavour.*

Maintaining the quality of nursing service is the paramount challenge of the nurse administrator. It is the ever present job of the nursing staff. Miss Clare Dennison, in discussing this subject in the American Journal of Nursing (July 1942), emphasizes that nursing service and nursing care are not synonymous. The former includes those duties and activities which are not directly related to the care of the patient but which contribute greatly to expert bedside nursing. Among these are the posting of orders, securing supplies, assignment of personnel, contacting doctors and the proper use of countless forms. These phases of the nurses' duties are constantly increasing and limit the time for the "traditional" care of the patient, which also is undergoing continuous change.

Among specific examples of change are the following:

1. Fewer available professional nurse personnel, although more have graduated in recent years than ever before.

To augment their services, an increasing number of *auxiliary workers* is employed. They include trained practical nurses, ward helpers or aides, and clerks. The professional nurse works as a co-ordinator or team leader carrying the real responsibility for the patient. For this to be successful, the professional nurse must not only know nursing principles and techniques, but must understand and carry out the "art" of working effectively with other personnel. This is a relatively new discovery and only by educational programs can the situation be met adequately. "Assembly line" or impersonal care can easily result unless additional emphasis is placed on personalizing nursing care. Nurses are being criticized for what some call unwillingness to nurse the patient; the real answer is to be found in economics, demands made by medical science, and in supply and demand for services.

2. The ever increasing number of patients in hospitals, the majority of whom are admitted in late afternoon or early evening.

In many hospitals, the practice still exists of admitting patients directly to the floor, thereby depriving patients already in from having the care they need. Often this happens late in the day. Usually, fewer nursing personnel are available at this time and other departments which contribute to patient care are not always open or fully staffed. Hence, the nursing service carries out the work of other departments (e.g., maintenance, business, etc.). Valuable time is taken away from the personal care of the patient. Patient turnover is extremely high. It is not uncommon to have as many as nine patients discharged and the same number admitted to one floor in a twelve-hour period.

3. The increased time element in giving nursing care to patients: more medications, treatments, and diagnostic procedures are being ordered.

These frequently extend over a twenty-four hour period requiring more and better prepared professional nurse personnel, but permitting less rest for the patient (e.g., the administration of penicillin, intravenous infusions, and aerosol penicillin). Nurses are now asked to carry the responsibility for duties that formerly belonged in the realm of medicine (e.g., taking blood pressure, giving intramuscular and intravenous infusions). In our hospital, approximately 600 doses of penicillin are given daily. During a recent study, it was discovered that on four medical floors totalling about 130 medical patients, over 3,000 doses of medicine were given in nine days. Medications administered to surgical patients were proportionately as high and it was discovered that the preoperative preparation of the patient is both more intensive and more extensive (i.e., administration of blood, glucose and saline solutions, more complete laboratory studies, etc.).

4. More intricate surgical procedures, the success of which depends upon well prepared nursing personnel. (e.g. eye, brain, chest).

Refrigeration anaesthesia and early ambulation also vary the need for nursing care. All require more nursing hours and call for well prepared professional nurse personnel. During the operative and post-operative period, the services of one or sometimes two nurses are needed. However, the convalescent stage is now almost non-existent in hospitals because patients go home earlier.

5. More elaborate use of records, memoranda, request slips for laboratory procedures, et cetera.

These require *more* of the time of nursing personnel, frequently limiting the time for nursing care. It is true that hospitals are diligently seeking time-saving devices and installing equipment to reduce the actual work load but much has yet to be done to use nurse personnel more wisely.

6. The increased number of patients with psychiatric and social implications, and those with tuberculous conditions.

All require more nursing time, a better understanding of the patient as a person, and the knowledge of procedures and treatments once not included in the care of patients in general hospitals, including emphasis on teaching patients.

7. Organization of new departments which improve the care to patients.

Clinical investigation is not new

(Concluded on page 88)

**American Journal of Nursing, July 1942, p.774.*

An address presented at the Toledo A.C.S. Hospital Conference in January.

Basic Principles in Hospital Purchasing

Leonard P. Goudy,
Purchasing Specialist,
American Hospital Association.

TWO factors make it necessary that hospitals give serious thought to their purchasing policies and to the abilities of their purchasing personnel at this time: (1) Rising costs bring the cost of hospitalization to a point almost beyond the ability of patients to pay and (2) it is possible once again to make purchase. For the past several years it has been a case of getting supplies where possible and paying what was demanded; quality and standards were relegated to secondary positions.

While prices have decreased very little, if any, since the end of the war and repeated tests show that quality is, if anything, poorer, there are more commodities available and, since there is a choice, it becomes incumbent upon purchasing personnel to try to offset high prices by economical purchasing practices and the maintenance of quality. Hospitals need personnel able to procure supplies and equipment economically.

What hospitals should have purchasing agents?

Attempts have been made to answer this question by means of surveys. Many surveyors are of the opinion that hospitals of 100 beds or over require a purchasing agent and should be able to afford one because of savings that would be effected. More commonly, however, it is advised that hospitals of 150 beds and over should employ a purchasing agent.

What is this job to be done?

A very considerable amount of money, largely community funds or tax money, is spent by hospitals in equipping new structures, or purchasing supplies or equipment for their operation. An undetermined but very considerable number of hospitals are being built in United States and Canada at an average cost *for equipment* of approximately $1,300 per bed. There is then a further operating expenditure (for supplies et cetera) of $3.50 to $7.00 per day after they are put into use. Well over $900,000,000 are being put annually into the purchase of some 7,000 items in use in hospitals.

How is quality to be maintained?

First understand the use to which the article will be put. It is then possible to decide what will best serve the purpose. Will a cheaper grade of sheeting do? Is this an item that is going to be lost? Will it improve or detract from comfort of patients or the appearance of the hospital? Many factors must be taken into consideration in deciding what will do the job most economically.

Having decided what you want to use or should use, describe it. Write specifications. Until you describe exactly what you are ordering, there is no certainty about what you are going to receive. You have no yardstick for measuring deliveries. Fortunately, many buying specifications, and tests of quality as well, have been and are being written for you. They are practically useless unless you use them. I say "practically useless" because accepted standards do have some effect on products produced by industry. When ordering sheets don't just say "24 sheets, 72 x 108 inches", but know the thread count you want, the breaking strength, the weight per sheet, the shrinkage allowance and the amount of non-fiberous material that is allowed. These specifications have been written for you. All you need to do is to copy them into your purchase order and, upon receipt of the shipment, carry out a few simple tests to see if the sheets received are in compliance with your specifications. You might also include the width of hems. New specifications for hospital sheets to be distributed shortly will specify a one inch hem at both ends instead of a three inch hem at one end as previously. This is being done so the sheet will not always be put on the bed in the same position and thus wear will be more evenly distributed.

Similar specifications have been written for many other items of hospital equipment and supplies. Inexperienced purchasing agents are not to be excused for not making use of them. They are the ones who need their assistance most of all. Neither are experienced purchasing agents to be excused as they are the ones most likely to appreciate them and make use of them.

No small part of the purchasing agent's job is *research*. Under this heading might be listed: what to purchase, considering the use to which it will be put; the repairs and maintenance it will require; its adaptability when new features are available; and a host of details linked with local factors, such as the type of staff employed.

A study of *markets* and *price trends* might be listed under research. There is, for instance, considerable variation in the quality of canned goods depending upon the area and the time of year in which it is packed. Attention to price trends is no less important than the study of markets. Industry has always done this and we might well take a leaf from their books. In recent months industry has reduced inventories down to 30—60 days supply since there would appear to be a possibility of a break in prices.

Having decided what will best serve our purpose, we must then *purchase as economically as possible.* Boiled down, the job to be done amounts to having the right supplies of the right quality in sufficient quantity in the right place at the right time and purchased as economically as possible.

An address at the Ontario Institute for Hospital Administrators, London, in April. Mr. Goudy was formerly administrator of the Saskatoon City Hospital.

Who is to do this job and where are we going to find him?

The purchasing agent should have technical knowledge and should be able to meet salesmen and discuss the merits of their products with some authority. For this he should have some special training. However, no formal training is available at the present time to those aspiring to be hospital purchasing agents. Purchasing institutes sponsored by the American Hospital Association have been helpful. Much literature has been published on the subject and, unfortunately, it deals largely with the experience of individuals. Very little group thinking upon this subject appears to have been done. The American Hospital Association is aware of the need for some formal training for hospital buyers and hopes to be able to make it available before too long. However, before a course of any kind can attract suitable personnel, administration must be made aware of the necessity for individuals trained in sound purchasing principles and economical practices in order to create opportunity for employment.

To obtain the best co-operation with other members of the staff the purchasing agent should be placed at department head or executive level. While he should not have the authority to purchase without consultation, he should at least have authority to make inquiries. He should be directly responsible to the administrator, meet with committees of the medical staff and have the prestige of meeting with the purchasing agents of other institutions or industry on an equal footing. Certainly he should not conform to the description given by Morse as quoted by Lacy: "Next to the Wall Street banker a purchasing agent is the lowest form of animal life; placing 80 to 100 orders a day, the buyer should expect to make 80 to 100 enemies a day, except for the fact that most of them are already his enemies. And this he accomplishes without satisfying the people for whom he is buying who know they could have done it much better themselves."

How is this job of purchasing to be done?

The purchasing personnel has *not* been set up as the first line of defence against people who wish to sell to the hospital. They are there to find out how and where to buy what the hospital needs and to do it as economically as possible. Of primary importance is organization. It is now generally accepted that, for efficient and satisfactory operation, purchasing and stores functions should be centralized. In this way it is possible to combine purchases for several departments and thus take advantage of best quantity prices. Trained personnel without other duties which may be regarded as primary are able to give full-time attention to their job. Centralized purchasing creates a focal point for all purchasing activities and fosters standardization of commodities and equipment, policies, and performance.

Should the purchasing agent or the dietitian buy the food?

If there is co-operation between the two, there appears to be no reason why the purchasing agent should not make the actual purchase and record it in co-operation with the dietitian. She, as well as other department heads, should be consulted about requirements, but the well-trained purchasing agent with sufficient time at his disposal is the one who should know about marketing practices, price trends, packing seasons, specifications, contract terms, and tendering procedures.

The situation becomes more difficult with regard to *pharmaceuticals*. While the purchasing agent can become familiar with the purchase of meat and groceries in a comparatively short while, it is doubtful if he could ever satisfactorily purchase pharmaceuticals other than in co-operation with a pharmacist. It is satisfactory, however, for the pharmacist, having interviewed salesmen and checked his stock, to transmit his needs to the purchasing agent, allowing the latter to complete the transaction, thus maintaining the purchasing procedure and records.

Records are of great importance to the purchasing agent.

His record of purchases tells him what has been purchased in the past, in what quantities and where, when and at what cost, what the terms were and frequently other useful information. His stock record or perpetual inventory tells him what happened to his stock and how much of it is left. It tells him when to reorder. He may set up other records for his convenience and control records are usually maintained by the accounting staff.

The purchasing agent must have a *planned procedure*. This would normally start with a system or service that would keep him informed of new products and this in itself is a large job. A group of 264 teachers recently found it necessary to arrange with a service bureau to inform them of new products and new advertising—to keep them abreast of the times. The purchasing agent's procedure must keep him informed not only of requirements in the hospital but of impending shortages. His stock record and list of shortages from the stores department will be his chief source of information. He must be familiar with specification writing, tendering procedures, contract terms and trade practices. His inventories should be controlled according to price trends and availability of supplies. The purchasing procedure will include such essentials as receipt of shipments and recording articles as they are placed in stores, proper storage of supplies and controlled issuance.

Specification Buying

Specification buying is one of the best safeguards available to hospitals in maintaining quality, and is the tool of experienced purchasing agents. Unfortunately, those with less experience, the ones who would derive most benefit, are not sufficiently familiar with the standards that have been set to make best use of them.

The American Hospital Association, through its commitee on Purchasing, Simplification, and Standardization, is working with the National Bureau of Standards as well as other interested organizations to extend its list of official standards and simplified practice recommendations as quickly as possible. You are, no doubt, familiar with the *Manual on Specifications* which was printed in 1940 and contains some 244 specifications for hospital equipment and supplies. Since that time more standards have been adopted and several simplified practice recommendations have been drawn up. The most successful one so far has been our simplified list of hypodermic

The Hobby Corner

3. G. Edward Tremble, M.D.

"Open Water in March"

FIRST prize winner in painting at the Fine Art and Camera Salon at the Canadian Medical Association convention in June was Dr. G. Edward Tremble of Montreal, associate laryngologist at the Royal Victoria Hospital and assistant professor of oto-laryngology at McGill University.

It was fitting that the Banting plaque in bronze should be awarded to Dr. Tremble for he has long been recognized as one of the leading physician painters of this country. Dr. Tremble has received most of his inspiration from the wonderful winter scenery in the Laurentians so close to Montreal. He has a cottage at Ste. Agathe and does his preliminary sketches there, the canvasses being finished or worked up on a larger scale in his studio in town. We understand that Wednesday afternoon is sacred to his hobby and nothing short of a post-operative hemorrhage (which, of course, never happens to his patients) can drag him away.

His prize-winning picture is typical of his work—good composition, rich colouring and superb technique. Starting some ten years ago, Dr. Tremble very wisely obtained helpful instruction and criticism from Mr. Sherriff Scott, noted Montreal painter. He found the time and effort well spent indeed. Like many others, he started in watercolours, but abandoned that medium in favour of oil.

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needles whereby the number of sizes and types have been fairly generally reduced from 100 needles, that were manufactured and sold, to about 20 needles.

Specification writing is intended to be used more directly by purchasing personnel. An effort is made to write standards high enough so that industry will not be inclined to manufacture down to a new level and still they must not be so high as to increase the cost of commodities. We endeavour to write specifications so that they can be readily understood by non-technical personnel, to include tests that can be carried out without elaborate equipment or trained technicians, and, at the same time, not depart too widely from ordinary commercial practice so that articles as specified will be obtainable.

To derive the greatest benefit from this program the purchasing agent should: (1) condense specification when placing orders to short buying specification, to be written upon the purchase order; (2) check merchandise on delivery against the order; (3) make as much use as possible of performance tests in his own institution.

Group Purchasing

It is difficult to measure the benefits of group purchasing in dollars and cents since no particular group buys all commodities for any one group of hospitals. The oldest buy-

(Concluded on page 72)

The AUXILIARY in Hospital Service

Edithe Paynter,
Winnipeg, Manitoba

THE terms hospital aid, auxiliary or guild, generally speaking, mean the same thing. They are all groups of women banded together to help the hospital and are made up of the very best material of its kind in the whole world. If you think that is too big a claim, just look around at the women who belong to these groups all over Canada. The term aid, perhaps, is a bit confusing. The public at large or, at least, the unthinking public, has a hazy idea that an aid dons a uniform and helps on wards. This has been done in cases of emergency, but it is not our objective.

During the recent war years, and even since, the demand on women's time and energy has increased tremendously and household help is almost a thing of the past. The increase in energy expended in shopping for the most ordinary and necessary commodity is almost unbelievable and might easily be made not just an excuse but a good reason for curtailment of extra work. But, the actual fact is that women have redoubled their efforts on behalf of hospitals. These facts speak for themselves.

There are three main functions of an auxiliary and the one that seems to loom up highest, which consumes the most time, effort, ingenuity and, to my mind, is the least important, is that of financial aid. Do not misunderstand that last statement. In the case of the smaller hospitals and hospital units that are manned only by two or three nurses and a doctor or part time doctor, financial help is definitely needed. Not only here but in many of the larger hospitals the superintendent has a feeling of well-being when he or she harbours some pet project, which could be omitted, yet if obtained, might be most beneficial both to hospital and patient. It could easily be turned down by a Board of Governors but get a sympathetic hearing by the women's auxiliary.

We should not overlook the effort put forth in raising money for these projects. Most people who have not worked in groups simply take for granted that a tea or bazaar just happens, but all women who undertake these affairs know the careful planning, the many interviews, the telephoning, et cetera, that must be done if such functions are to be successful. Yes, the financial support is necessary but not the only goal.

Never-ending Tasks

The second function of a hospital auxiliary is the practical day by day assistance which the hospital receives.

Without interfering with the work of the staff, members of aids have, in many cases, undertaken practical work which has meant a great saving in nurses' time and energy. They care for and arrange flowers. (To a nurse this task is a necessary evil that must be attended to and she has so little time in which to do it.) They dust wards, answer calls and discharge patients, telephone for patients, direct visitors, run elevators, drive patients to and from hospital, and act as chauffeurs for nurses who find it necessary to make house visits. Then there are many hospital patients and staffs enjoying home-made jams, jellies, pickles, et cetera, because the members of the aid are willing to contribute their time in order to prepare such delicacies. This work is done in the evening when women might feel they had a right to relax and enjoy their leisure. The kindly thoughts manifested in these services, as well as the dainties in themselves, are most appreciated by a busy, harassed, superintendent.

We might add here a short paragraph on moral support, that intangible thing we all need at times. Someone to tell us how well we are doing and how well things are going. There are bound to be days in the life of any administrator when she feels the world is all wrong and that she is almost a failure. Then if she can come to her group of "true friends", her hospital aids, and unburden some of her difficulties, she can obtain a sympathetic and understanding hearing even if they cannot solve her problems.

Public Relations

The third function is the most important of all, i.e. public relations. In the minds of many people, hospitals are necessary evils—necessary, but nevertheless evils. I suppose the reason for this is that until an individual needs hospital care for himself or family, he does not give it a thought, except to listen to unfair criticism levelled against the hospital. Generally, these criticisms stem from ignorance of the true facts. Here it is that members of aids can really help for they should have an intimate knowledge of their hospital and be able to stop false rumours that are often ridiculous and unfounded. Besides contradicting unwarranted criticisms, they can spread news of the benefits of a well conducted hospital to the community and, being members of society, friends and respected neighbours of the rest of the community, they should be able to mould public opinion.

And so this is another field teeming with opportunities for women. Indirectly an interested group can give valuable service to the public health of their community and to that of the province. Those of you who are members give enthusiastic and loyal service and enlist the sympathies and co-operation of your large list of friends and acquaintances. Is it not true that the truest happiness is to be found through serving others and in the giving of ourselves to help others.

"For the heart grows rich in giving,
Self-entwined its strength sinks low.
It can only live by loving
And by serving love will grow."

Miss Paynter is third vice-president of the Manitoba Hospital Aids Association.

Out-Door Movies for Veterans

A. T. Paton,
Public Relations Officer, Department of Veterans Affairs, Vancouver.

Out-door movies for patients in Shaughnessy Hospital's Chest Unit are a weekly feature. Isolation cases view the screen through the window and hear the sound track through their radio head-sets.

MOTORISTS who drive to those new-fangled outside movie theatres to watch a show from their cars have nothing on the tuberculosis patients confined to their wards in the Chest Unit at Shaughnessy Hospital in Vancouver. Once a week these veterans see and hear one of the current films without even leaving their beds, let alone their rooms.

Last summer P. H. Loveridge, district recreational supervisor, set out to devise a method whereby these veterans would enjoy the same entertainment as the patients who were able to go to the auditorium on movie nights. Since the positive tuberculosis cases could not be moved he planned an ingenious way of bringing the films to them.

An 8 x 10 foot screen of white rubberized material is erected on the lawn about 80 feet from the building. Located at an open window opposite the screen is the projector. The regular speaker is placed next to the projector but it is used by the operator only as a monitor, since the sound is brought to each onlooker individually through a radio head-set. Thus one patient may enjoy the show without fear of disturbing his neighbour who might be too sick to listen.

The projector is started and the patients settle back to see the picture through the windows. A light flexible wire cable, plugged into the second speaker outlet and a head-set wall outlet, conveys the sound to the audience, each of whom can control the volume to suit himself. Head-set extensions are provided for those who have to move their beds closer to the window to see the performance.

With this set-up the patients in one 150-foot section of the building (of which there are four) are within range of the screen. These outside movies have become so popular that the doctors in charge permit the patients in each section to stay up until 11:15 one night a week for the show.

Graham Stephens Accepts New Post

Mr. Graham F. Stephens, formerly of Winnipeg and son of the late Dr. George F. Stephens, who is now assistant director of Barnes Hospital and Washington University Clinics, St. Louis, as well as associate director of the Department of Hospital Administration, Washington University School of Medicine, has resigned these positions and will become administrator of George H. Geisinger Memorial Hospital, Danville, Pa.

This is a 225-bed hospital which has a full-time medical staff of 18, organized in the Mayo tradition. A large clinic building is to be erected in the spring.

H. C. Allnutt Accepts Appointment in Sherbrooke

Mr. H. C. Allnutt, who has been superintendent of the Herbert Reddy Memorial Hospital in Montreal since September 1943, has resigned that position to become superintendent of Sherbrooke General Hospital, Sherbrooke, P.Q. He assumes his new duties this month. The Sherbrooke General is at present a 100-bed hospital and plans have been prepared for the construction of a new 150-bed institution.

Drug Therapy — *and the Administrator*

Hans S. Hansen,
Administrator,
Grant Hospital, Chicago.

IN reviewing the history of the use of drugs, which is as old as man himself, we find that empirical therapeutics lasted up to the present century and, in some instances, even later. At the beginning of this same century, there developed within the medical profession a group of doubters of drug therapy. These therapeutic nihilists were partly responsible for the development of drug research as we know it today. This research program has, in itself, developed and passed through many stages until today we have it epitomized in the Therapeutic Trial Committee of the American Medical Association.

All through these years the fine art of compounding practised by the pharmacist has been gradually replaced by the manufacturing processes of the large pharmaceutical houses. These manufacturing companys produced medicinal products that could be dispensed with a minimum of knowledge on the part of the dispenser and with a minimum of danger to the patient. This, probably, as much as any single fact, led hospitals to operate without the services of a pharmacy department.

Administrator's Responsibility

There is no question that the hospital administrator should pay more attention to drug therapy, for at least two reasons.

1. *Chemotherapy*

The introduction of chemotherapy and its continued development has brought the physician and surgeon materials of medicine for rational drug therapy. It can also be stated that a generation ago surgery was being made safe for the patient, whereas today efforts are being devoted to making the patient safe for surgery and this process requires the use of a great many drugs.

The sulfonamides, though somewhat over-shadowed by the more dramatic antibiotics, are still very important. Research work is still being carried on with this group. This will bring forth many new members. While some thirty or so antibiotics have been discovered, with the release of only three, research has just begun. Pharmaceutical interests are now sampling soil from all parts of the world in efforts to discover additional chemotherapeutic agents.

The scientific literature and commercial information on sulfonamides and antibiotics, to say nothing about replacement therapy, including the use of the endocrines, has become so voluminous that the busy physician must have help in order to keep abreast of all the new developments. It then becomes the duty of someone to summarize all the literature for the physician. What more logical agent than the hospital through its pharmacy department? All literature reviewed by the pharmacist should be available to the physician in a well stocked and organized *pharmaceutical library.*

The care and distribution of these potent and, in some instances, dangerous drugs, need the skill and knowledge of a well trained pharmacist. The pharmacist in turn, in order to care for these, must have adequate tools and equipment.

2. *Economic Implications*

The second reason a hospital administrator must pay more attention to drug therapy is its economic implications. Before the introduction of the sulfonamides, and more particularly the antibiotics, it was estimated that it requires an investment in drugs of twenty-five to thirty dollars per hospital bed. This figure varied somewhat, depending upon the buying habits of the hospital, prescribing habits of the staff physician, and whether or not the hospital maintained an outpatient department. I believe I am safe in saying that the advent of these drugs has increased the inventory of the pharmacy department thirty to forty per cent. Some of this increased overhead can be offset by lowering the inventory of some of the drugs which these have replaced. But keep in mind that this is only the beginning of chemotherapy. Other sulfonamides will be released and this is true even more so in the field of antibiotics. Antibiotics will be introduced that will "out-penicillin" penicillin. So with all this and the increased use of the expensive endocrine extracts, your drug inventory will increase rather than decrease.

Today the physician has available drugs that he can depend upon to produce results—rational therapy. It naturally follows that he is going to use more of them. Here, then, is an item that the hospital can dispense, through its pharmacy department, at some profit. I am sure that this is a legitimate profit, and one which will help hold back that ever-narrowing spread between between operating income and expense.

In closing I want to leave this thought with you. You expect your medical staff to practise self-improvement with or by the use of clinical conferences and staff meetings. Is it not reasonable, then, to expect the same of your pharmacy department? This they cannot do if they are understaffed so that their work is on a production line basis, leaving them no time for study and research.

From an address presented at the A.C.S. Hospital Conference in Toledo.

Ottawa Sets Up Department of Civil Aviation Medicine

From Ottawa comes the announcement of the formation of a division of civil aviation medicine within the Department of National Health and Welfare for the purpose of studying the medical aspects of flight. Dr. H. E. Wilson of Ship Harbour, N.S., and formerly R.C.A.F. wing commander, has been appointed to head the division. He will work in close touch with the Department of Transport in developing and maintaining medical standards for civil aviation personnel and in studying the medical regulations affecting the safety, comfort and health of flying personnel and air travellers.

The Survey of Medical Incomes

LAST autumn the Dominion Bureau of Statistics, with the co-operation of the Canadian Medical Association, conducted a survey of the incomes of doctors in Canada. This was released to the press in June.

Questionnaires were mailed to all physicians in civilian practice in 1947; salaried physicians were included. The survey was confined to those doctors who were in civilian practice in any of the four years covered—1939, 1944, 1945, and 1946—but inasmuch as the D.N.H. and W. mailing list was used, doctors leaving the profession before 1947 were not covered. Income from services in the armed forces is not included. The response rate was 53 per cent, but, on the basis of usable and relevant replies, the responses for the respective years ranged from 36.7 to 49.0 per cent. D.B.S. officials considered the replies quite representative.

Net Incomes

The average net income for Canada and by regions was as follows:

	1939	1945	1946
Canada	$3900	6200	5800
Maritimes	4000	6300	5600
Quebec	3400	4700	4800
Ontario	3800	6400	5800
Prairies	4100	7100	6400
B. C.	4700	7800	6700
No. of doctors in civilian practice	11,503	9829	11,651

Doctors on *salary* averaged lower incomes than those in *independent practice*. Highest incomes went to those combining salaried work and independent practice:

	1939	1945	1946
Salary	$3800	4600	4400
Independent Practice (Net)	3600	6300	5900
Practice and Salary	5000	7800	7500

For the second group, those in independent practice only, the gross income in 1946 was $9,500, a drop from $9,900 in 1945. Net income was 61.8 per cent of gross.

On a regional basis, highest gross and net incomes in the second group were in the west:

	1939 Gross	1939 Net	1946 Gross	1946 Net
Maritimes	$6300	3800	9200	5800
Quebec	4900	2800	6900	4000
Ontario	6000	3400	9400	5700
Prairies	6500	3900	11,600	7300
B. C.	7700	5000	12,100	8100

While 37.4 per cent of the doctors had total net incomes over $4,000 in 1939, the figure rose to 62.4 in '45 and 58.2 per cent in '46. Although only 4.2 per cent had total net incomes over $10,000 in '39, 17.0 per cent exceeded this figure in '45.

Specialization

Net income appears to vary directly with the degree of specialization among the independent practitioners reporting:

	1939	1945	1946
Gen. Pr.	$3000	4900	4500
Partly Specialized	4400	7700	7000
Fully Specialized	5100	10,000	9700

Incomes by specialties show considerable variation:

	1939	1946
Internal Medicine	$6100	8400
Surgery	6300	12,300
E.E.N.T.	5100	9100
Obs. and Gyn.	4800	13,500
Paediatrics	3600	8400
Other Spec.	4500	7400

The income of doctors increased directly with the years of post-graduate training:

Years of P.G.	1939	1945	1946
0	$3000	4300	4000
1	3400	5400	4800
2	4200	6700	6200
3 to 5	4500	7800	7500
6 and over	4500	8200	8300

Rural vs. Urban

Incomes analyzed by the size of the community reveal higher incomes in smaller cities than in the large cities:

Population	1939	1945	1946
under 100	$2400	3500	3200
1000 — 4999	3100	4400	4200
5000 — 24,999	4400	8100	7100
25,000 — 99,999	4600	8500	7400
100,000 — 499,999	3800	8200	7800
500,000 and over	3500	5900	5700

Doctors with both salaried work and independent practice average higher in all sizes of centres. To use 1946 as an example:

Under 1000	$5100
1000 — 4999	5700
5000 — 24,999	6700
25,000 — 99,999	7900
100,000 — 499,999	8400
500,000 and over	8600

Years of Practice

The average net income from independent practice plus salary in 1946 revealed the highest incomes at from 15 to 25 years after starting practice:

Years in Practice	
Under 5	$3400
5 — 9	6100
10 — 14	7300
15 — 19	7800
20 — 24	7900
25 — 29	7300
30 — 34	6600
35 — 39	5300
40 and over	3400

Salaried Remuneration

Replies from salaried doctors analyzed as follows:

	1939	1945	1946
Medical Teaching	4100	4500	4900
Hospital Service*	3500	4400	4300
Industrial Medicine	4000	5300	5400
Public Health	3600	4100	4400
Other Govt.	3500	4400	4400
Med. Admin.	5500	6000	5900
Other Prof. Salaries	3700	5200	4700
Two or more of above	4800	5600	5600

Comment

This study reveals much information never before available in tabulated form—at least not to the extent here presented. In general, it substantiates the opinions on salary comparisons commonly held by students of medical economics.

Opinion will be divided as to the

*We are informed by Mrs. Kathleen M. Jones who made the analyses that this item of "hospital service" presented some difficulties. Interns and hospital superintendents are not included; the latter are classed under "medical administration". It does include all "full-fledged" doctors practising in government or public hospitals including residents. Full time radiologists and pathologists on salary might be included unless reporting under "other professional salaried work". Many radiologists might report as also having an independent practice. A D.V.A. hospital doctor might classify himself as in "other Government service".

wisdom of compiling these data at a time when professional incomes have been at an all-time peak. With much discussion as to the financial details of providing health care looming up in forthcoming health insurance discussions, these figures may well be quoted and re-quoted long after medical incomes may have dropped sharply in a depression period. We note how quickly the press singled out and headlined the observation that medical incomes had jumped 60 per cent in seven years. (The increase in most other vocations has been still greater). On the other hand, some people will be surprised to find that medical incomes average lower than they had thought.

What compilations like this cannot reveal is that in the professions, individual incomes vary wide of the average or mean. In that sense professional incomes differ from the trades, for instance, where wages are more or less standardized.

The comparatively low income of doctors in "hospital service" loses much of its significance on analysis (see footnote). Residents, fellows and other doctors, employed in civilian or governmental hospitals are included and, in these instances, the value of board and lodging has not been added. The exclusion of superintendents lowers the figure. We doubt if many full-time radiologists are included or the figure would be higher.

It is generally recognized, too, that a net income of, say, $5,000 in independent practice means a greater personal income than is provided by a $5,000 salary unless meals or other emoluments go with it.

Montreal Hospitals Increase Rates

Hospitals in the Montreal area will increase their rates, varying from 50 cents to a dollar or more according to the type of accommodation provided and the size of the hospital. The minimum public ward charge in some hospitals, now $4.50, is slated to go up to $5 in August. The present charge for semi-private wards is $6.50, which in a few weeks is expected to rise to $7.50. In the smaller hospitals the rates for private rooms are $9 a day, to be increased to $11.

In a statement dealing with the matter of increasing cost of operation, Dr. Lorne Gilday, secretary of the Montreal Hospital Council, remarked:

"In common with the general public, hospitals are finding that the increased cost-of-living is aggravating their perennial problem of trying to make both ends meet; a problem, which during the past few years, has been accentuated by the gradual falling-off of legacies owing to higher succession duties, and the lower interest rates received on investments by those hospitals fortunate enough to have an endowment fund".

Le Congrès Biennal des Deux Conférences A.C.H. de Montréal et de Québec

les 23-24-25 août, 1948

au Collège des Jésuites à Québec

1er jour, 23 août

Le matin

Messe et sermon, inscription, ouverture de l'Exposition des fournisseurs d'hôpitaux, plus de 50 kiosques.

L'après-midi

Orientation moderne et médecine — Docteur J. C. Miller

L'infirmière et la psychologie du malade — Docteur Georges Montel

Echos de l'Institut d'Administration Hospitalière tenu à Montréal en mai, 1948 — Révérend Père H. Bertrand, s.j.

2ème jour, 24 août

De beaucoup la plus importante, à cause des spécialistes de grande renommée qui en feront les frais et se prêteront à toutes les questions d'ordre pratique.

Le matin

Ethique hospitalière — Harvey Agnew, M.D., Secrétaire du "Canadian Hospital Council".

L'Evaluation en points — Malcolm T. MacEachern, M.D. Directeur Associé de "American College of Surgeons".

The American College of Hospital Administrators: histoire, organisation, recrutement — Dean Conley, Secrétaire de "American College of Hospital Administrators".

Archives médicales — Malcolm T. MacEachern, M. D.

L'après-midi

Le Directeur médical: sa nécessité, ses fonctions — Malcolm T. MacEachern, M. D.

Les évolutions de l'hôpital — Harvey Agnew, M.D.

Organisation d'un personnel médical — Malcolm T. MacEachern, M. D.

Forum sur des problèmes d'hospitalisation, projections lumineuses

3ème jour, 25 août

Le matin

Médecine psycho-somatique — Docteur Roméo Blanchet

Le secret professionnel — Monsieur l'abbé V. Germain

L'après-midi

Psychasténie — Révérend Père Samson, s.j.

Remerciements—Voeux—Résolutions

Here and There

Rev. G. MacGregor Grant, M.A.,
Toronto

Medicine and Witchcraft in Native Africa

The Story of
Sydney Gilchrist

I FIRST met Sid Gilchrist at Dalhousie University in Halifax, Nova Scotia. I was doing Arts, he was doing Medicine and we both lived in the same college residence. In a small university like Dalhousie, a few leading spirits always seem to dominate the campus. In my day half a dozen men seemed to stand out above the other students because they showed marked gifts of personality and leadership. Sid Gilchrist belonged to this little group of campus celebrities. He was the leader of the Dalhousie Debating Team and a brilliant public speaker. Gilchrist never needed any tips from Dale Carnegie on "How to Win Friends and Influence People".

During his college days, Sid Gilchrist decided to become a medical missionary. In 1930, accompanied by his wife and two small children, he sailed for Africa. Their destination was a Portuguese colony called Angola, situated in West Africa just south of the Belgian Congo, where the United Church of Canada has a mission. Here Gilchrist found an Ontario doctor named Walter Strangway who had gone to Angola two years before. They had only a small hospital with 10 beds but the two doctors began their work with courage and faith. Today each of them has a 70-bed hospital with 20 village dispensaries. They have 72 trained assistants and nurses, all of them natives. They perform 1000 operations a year with an annual mortality of about 2 per cent. What this medical mission means to that area I shall now show you.

In Africa there is one doctor for every 400,000 people. What this means in sheer human misery no one can estimate. In Angola, besides the ordinary diseases, Dr. Gilchrist has to deal with a host of tropical diseases which take a terrific toll of life. Malaria, leprosy, sleeping sickness, hook-worm, dysentery, tropical ulcers—such ailments as these create fearful ravages among the unhappy Africans.

Malignant malaria is the worst enemy, particularly among children where there has been a mortality rate of 60 per cent from this cause. A new drug, paludrine, is cheaper and more effective than quinine; it has proved a powerful weapon against malaria and has saved thousands of lives.

Pneumonia is another killer, due to the sharp seasonal changes. Dr. Gilchrist is particularly enthusiastic about sulfathiazole. Since he began to use sulfathiazole, his pneumonia mortality rate has dropped from 25 per cent to 1 per cent. You can imagine the amazement of the African who brings a dying relative to the hospital and sees the patient's temperature drop from 105 degrees to normal within 24 hours. To him it is sheer magic and his gratitude is unbounded.

Gilchrist has done a remarkable piece of work with leprosy. On any given day there are 200 lepers in his Leprosarium, all of them advanced cases. In addition to this, his native assistants treat early cases through their village dispensaries. These early cases are cured by the use of two more wonder drugs, promine and diasone. The results achieved by these drugs have been so successful that Gilchrist believes that leprosy can be stamped out in that area within two generations.

The work is enormously complicated by the native witch doctor and there is at least one in every community. In view of this, the religious instruction given by the Mission through Dr. Tucker and his colleagues assumes outstanding importance. The native is not happy with his own religion. To us, religion is a source of joy and strength. To the African, religion brings torturing fears and needless pain. Gilchrist insists that religion and medicine must go hand in hand; they cannot be separated.

When a native dies it is believed

Dr. Sydney Gilchrist and cured leper assistant giving treatments for leprosy in Angola village.

that his spirit remains in the house for two days until the funeral ceremonies are completed. To pacify the spirit and make him happy, the relatives must give him an impressive funeral. They hold a big feast to which everyone in the village is invited. But if the relatives are poor and cannot make a big show, the spirit is angry. He will go away for a time but he will return as an evil spirit and exact terrible vengeance.

This is where the witch doctor comes in. The African witch doctor is a fascinating figure. Usually he is a man of high intelligence possessing a considerable knowledge of elementary medicine. He is familiar with the jungle herbs and roots which have healing properties. He can even perform a cataract operation. He squeezes the juice of a plant with anaesthetic properties and pours it into the eye to numb it. Then using a sharply pointed stick of particularly hard wood, he removes the cataract. Centuries before Edward Jenner discovered vaccination, the African witch doctors were preventing smallpox by this method.

If the witch doctor cannot cure a disease, and this frequently happens, he has an excellent alibi. He announces that some malignant person has put a spell on the patient and calls the tribe together to determine who the guilty person is. Dressed in a costume of skins or feathers, he dances around to the sound of drums, shaking his divining basket and muttering weird incantations. Suddenly he stops and pointing to someone in the crowd he names the guilty party. The poor wretch protests his innocence, but all in vain. Punishments are varied but they are all marked by a refinement of cruelty. No one disputes the decision of the witch doctor.

The witch doctor practises preventive medicine but his is slightly different from ours because it is based on a system of charms. If you want to avoid malaria or leprosy you buy a charm from the witch doctor and to get this you pay through the nose.

Let me give you three simple illustrations to show you how African superstition impedes the work of the Christian doctor. Tuberculosis is very common and, as you know, fresh air and sunlight are essential in its treatment. But the native houses, damp, dark and stuffy, have no windows. Why? Because if they had windows the evil spirits would peek in after nightfall and select their victims.

One day a woman was brought to our Mission Hospital in a dying condition, because of severe burns. She had taken an epileptic seizure, fallen into a fire and lain there until she regained consciousness. Her husband had stood by without lifting a finger to help her. Why? Because he believed that an evil spirit was inside her causing these convulsions. For this reason no African dares to touch an epileptic.

As a third illustration, one day a certain village reported a bad outbreak of malaria. This was puzzling for the village was located in hilly country, five miles from the nearest swamp. You can't have malaria without mosquitoes. But where did the mosquitoes breed? At last the doctor found the source of the trouble—some large fetish pots full of water for ceremonial washings. These were teeming with the larvae of the death-dealing mosquitoes. The village chief was urged to empty the pots immediately, whereupon the witch doctor declared that if anyone touched those pots, the spirits would be angry and some great calamity would come to the village. His advice was taken and the malaria raged on unchecked.

From earliest childhood, the African lives in mortal dread of evil spirits. When he is a baby, every time he yawns, his mother puts her knuckle in his mouth. Why? To prevent an evil spirit from slipping down his throat. As children grow older, they are never allowed to go out of doors after nightfall. Spirits, prowling in the shadows will count the children. "One, two, three, four. Aha! There are too many children in that family. We will take one away by a wasting fever." A common name for a boy in Angola is "Cano", meaning "Worthless Thing". The Angola mother thinks she is very clever, for the spirits, hearing the name, will decide she doesn't love the boy. And if she doesn't love the boy, obviously they can't punish her by killing him.

Paths in an African forest take a turn every 20 feet; they are made that way deliberately. Why? So that spirits can't see around the corners and won't know that a traveller is coming.

In Angola, gastric ulcers are very common, much more so than in Canada. This is not due to the diet. Our doctors believe that the main contributing cause of these ulcers is fear, in the shadow of which the poor African walks from the cradle to the grave—fear of the witch doctor with his spells and his poisons, fear of malignant spirits who are always plotting mischief. So it is that the Christian religion which we accept so casually, comes to the African as a thrilling discovery. For it assures him that he is not a helpless victim of malicious spirits, but a child of God, surrounded by God's loving care. There is one saying of Jesus which means little to the Canadian, but to the African it means everything: "Ye shall know the truth and the truth shall make you free."

Claims Refugee Doctors Lack Bedside Manner

"Arrogance and an attitude of superiority characterize many of the foreign physicians who seek New York licenses," says Dr. Jacob Lochner of the state's licensure board. On the whole, says Doctor Lochner, the foreign candidates have no understanding of or patience with the American ideal of the physician-patient relationship.

On top of that, he reveals, from 72 to 78 per cent cannot pass the state examinations, and failures are often followed by loud complaints to the state and federal legislatures. One fourteen-time flunkee, says Doctor Lochner, brought a Congressman into the licensure office to investigate the "treatment" he was getting.

—*Medical Economics*

Rent Your Own Doctor

The medical profession in Toronto would seem to be experimenting with a new type of medical practice. We note in the latest issue of the *Bulletin of the Academy of Medicine* in that city the following boxed advertisement:

FOR RENT

2 large doctors, offices with mutual waiting-room, freshly decorated, for use separately or as a unit. Private entrance . . .

Food and Its Service

Sponsored by the Canadian Dietetic Association

Food to the Fore

E. M. Yvonne Love, B.Sc.,
Consultant on Nutrition,
B.C. Department of Health and Welfare, Victoria.

IN these days of rising food costs, we may well say that in many ways food is to the fore. Although the proportion of the expenditure for food may differ in many institutions, it is always a major item of expense.

Keeping Costs Down

Let us consider the importance of food from the standpoint of food economies. An interesting remark was made recently at a meeting of the Restaurant Association—"for too long we have been charging the public with our inefficiencies". I wish to stress the ways by which food costs may be kept down.

a. Figure food costs per serving ahead of time of serving—not after food is eaten.

b. Use standard servings according to size of pans, slices to the pound, et cetera.

c. Know food yield of recipes used.

d. In hospitals serve quantities appropriate for the appetites of sick people.

e. Learn taste preferences of the general public.

f. Estimate shrinkage of foods, and figure this in cost.

g. Know food, food alternates, and use this knowledge in economical purchase of wholesome foods.

h. Follow trend of economies—serve local products when possible to obtain same food content as that in imported foods.

i. Raw food cost plus labour cost plus overhead equals total food cost. This should be considered when planning menus, and in ordering ready-to-serve items, e.g. baked goods or ice cream desserts.

Avoid waste. Waste can be eliminated by careful analysis of food planning, purchase, storage, preparation and service. Small amounts of waste all along the line are what contribute to the sum total—not large waste in any one place.

Overall food costs may be reduced in the following ways:

a. Cut the quality, but first, ask yourself, "Can we afford to do this?";

b. Reduce the quantity of the serving;

c. Cut cost of food preparation and service.

There is such a thing as false economy. This may apply to raw food, kitchen equipment and even to kitchen staff. One must analyse the situation carefully in order to eliminate waste and inefficiencies of operation while avoiding measures which affect adversely the general efficiency of the department or impair the quality of the meals.

Planning Balanced Meals

Food is important from the standpoint of its physical qualities. Hospital meals may serve as a pattern to patients whose food habits need to be improved. Hospital meals should be wholesome—based on an adequate daily pattern. They should be well planned, properly prepared and effectively served. A simplified menu will give the most satisfaction in that there will be more time left to concentrate on food preparation, and efficient service. A good basic menu pattern to follow is that outlined in *Canada's Food Rules:* Serve a moderate amount of the five main food groups—milk, fruits, vegetables, cereals and bread, meat and meat alternates—for a well balanced diet.

Planning in the food department is as important as in the administration of the whole hospital. The fundamental operation of the food department is based on these plans:

a. The menu plan, which should be planned for at least a week in advance;

b. The food requisition or market order—based on the menu plan; staple foods may be ordered on a monthly basis, depending on conditions;

c. The work plan—also based on the menu, and for the purpose of delegating work and responsibilities.

Staff

1. First, it is important that you give time and consideration to the hiring of staff;

a. Select personnel for a specific job;

b. Learn all you can about the prospective employee as to experience, and aptitudes.

2. When hired, give the employee a proper introduction to the job. It is most important that those who are hired be given every assistance toward doing an efficient piece of work.

3. Explain all related jobs, and in addition give them some orientation in the hospital world which they have entered.

4. Explain principles of hospital management inasmuch as it affects the employee.

5. Delegate "on the job training" to one of the employees capable of taking on this importance piece of work.

6. Delegate responsibility to your staff to give them greater interest in their work and to lead them on to greater accomplishment.

7. Make an opportunity for employees to learn and advance.

8. Give constructive criticism and encouragement to employees.

9. Give praise where praise is due.

10. Hold staff meetings and encourage discussion of problems; accept and analyse staff suggestions.

11. Provide adequate lockers and staff rooms and pleasant surroundings.

12. Investigate employees' hours and pay.

13. Give a sense of security to employee.

14. Develop a spirit of friendliness.

15. Show respect toward each employee.

16. Live up to regulations and the staff will do the same.

17. Encourage group recreation and parties.

18. Build up loyalty by your treatment of the individual.

Two important points to remember:

a. The satisfied employee is a good advertisement;

From an address presented at the two-day institute for administrators in Victoria, 1947.

b. Happy people do better work and happy people radiate contentment to the patient.

Equipment

Good equipment is necessary for the efficient operation of a food department. Proper economies must be administered, but here again false economy will not pay. Labour saving devices will assist the staff in carrying on their work to the best of their ability, in the shortest time, giving the best results.

Equipment, well chosen, must be well arranged. To do this effectively, it is necessary to analyse the many operations which are taking place in the food department. Mainly, these will fall into three sections—preparation centre, serving centre, and cleaning centre.

In addition to this, adequate receiving and storage space is essential in the department. Here again efficient equipment contributes to prevention of food waste and proper arrangement prevents waste of employees' time and effort in the performance of their duties.

Arrange the food department in as far as possible so that there is a direct flow of food from receiving and storage units, through the preparation and serving centres, and on to the patient, with a minimum of waste in space, time and effort. Having equipment well-placed will save many hours of time for kitchen staff and eliminate much confusion in the preparation and serving of food, and also in the final stage of cleaning up.

Food Psychology

Aside from the physical aspect of food, there is the psychological aspect. It has been said that "Eating is America's favourite indoor sport". Certainly, in the case of patients, mealtime looms as an all important event.

Although the patient is on his back and cannot always speak for himself, as much salesmanship is required in presenting food to him as is necessary in commercial food establishments, where the utmost in advertising is used to keep up the volume of business. Through clever salesmanship the patient can be made to want, accept and enjoy the wholesome food which is available on the menu. One must remember to follow such important rules as: serve hot foods hot; cater to the taste preference of the general public; make the patient feel you are catering to him; feature treats. Above all—remember that there is fun in food.

All these things will promote a feeling of contentment in the patient, and he will be made to forget his ills, in retrospect.

A healthful attitude toward food is an important attribute to develop in staff and patients alike. Long lists of food dislikes might better be avoided and more satisfaction will be gained by the patient because of his acceptance of the wholesome, well prepared, attractively served food which arrives three times daily on his tray. It is, of course, the responsibility of the head of the food department to see that this delectable food is available. It is also just as important that the cup is as conveniently placed on the tray as it is when on the hotel dining room table. We must be as considerate as possible of the patient, who has been wafted to the hospital and is expected to adjust himself immediately to the different hospital meal hours and all the other idiosyncracies of hospital life, in addition to becoming adjusted to his changed physical condition.

The welfare of the patient is based on medical and surgical care and many special services, of which food service is only one. But through good food the patient is helped toward quicker recovery—an advantage to patient and hospital alike. Thus the food department takes its place in the integrated services, all of which are directed toward the welfare of the patient. He in turn, as a well satisfied customer builds up your reputation. In the final analysis, when the man is cured and is discharged, if asked his impression of the hospital, he will invariably reply, "The food was good" or "The food was horrible"—only then will he go on to tell you of the nursing care and of his operation! This is undoubtedly due to the fact that food is prominent in the mind of the individual. As in the case of housekeeping, the patient feels he is competent to judge good food and thus is in a position to criticize.

Dermatitis from Handling of Streptomycin

During the last two weeks of February, 1948, some members of our nursing staff complained about a peculiar itchy swelling of the eyelids but not affecting the conjunctiva. On questioning further it was found that those presenting this oedema were amongst the nurses handling streptomycin. Only nine nurses in the hospital were found to be daily and routinely preparing and giving the drug. All of them had been dealing similarly with the drug for an average period of 10 months. Of the nine nurses, five are now presenting allergic manifestations to streptomycin. In all of them the first evidence of sensitivity appeared more than eight months after the first contact with the drug.

A transient pruriginous or non-pruriginous polymorphic skin eruption on hands and forearms was noted. The distressing symptoms that brought these nurses to seek care was a pruritic oedema of the eyelids; in one instance this was marked enough to awaken her during sleep. No evidence of blepharitis or conjunctivitis, as had been reported, was noted. The oedema was marked, appearing four to eight hours after contact, and affecting more frequently the upper lids. In some cases the eyelids were fissurated, and brown discoloration with fine desquamation was present in one case.

Of the five sensitized nurses, three had a history of various allergies. However, in none of these had streptomycin produced any reactions prior to February, 1948.

Oedema and pruritus disappeared within 24 hours if contact with the drug was avoided. Symptoms reappeared every time the drug was handled again, and increased in severity with prolonged handling.—

Dr. Jacques Gelinas, Ste. Anne's Hospital, Ste. Anne de Bellevue, P.Q., in June "Treatment Services Bulletin".

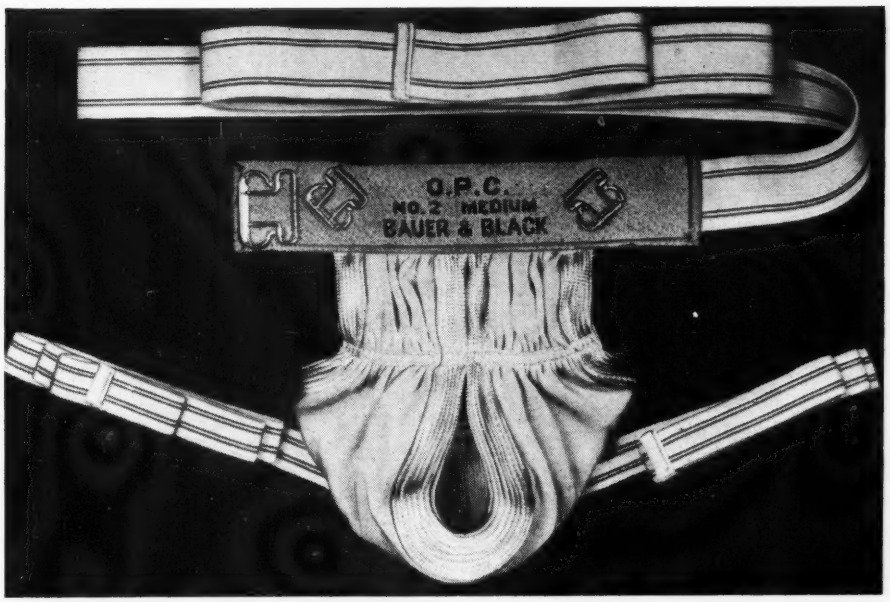
Charges to Private Patients

It is open to question whether private patients, most of whom have their own problems of meeting obligations out of income, should be called on to help treat those who are charges on the community, as well as paying their own way.

—Montreal Gazette

Your Patients will like

BAUER & BLACK O.P.C.* No. 2



Just a quick look at Bauer & Black O.P.C. No. 2 Suspensory will show you why so many doctors prescribe it to patients. For every detail of this fine suspensory—from excellent materials to careful sewing — reflects quality. Most important, O.P.C. is tailored for comfort, so patients *will wear it.* Yet the cost is low to meet your patients' budgets. That's why we say "OP.C. — your patients' best buy."

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FEATURES:

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FULL RETENTION OF SCROTUM, through properly placed leg bands, regardless of patient's position. An important advantage for patients in *active* work.

WAISTBAND—long stretch elastic permits removal of suspensory without unbuckling. Assures better fit without bulky padding.

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Physician Artists Display Works in Two Exhibits

AT the conventions of the Canadian Medical Association and of the American Medical Association this year, physician artists and photographers again displayed extensive exhibits of their art work during past months. In both instances the works exhibited were all of a fine order and many individual contributors showed distinct improvement over the work which they had submitted on previous occasions. It was unfortunate that both conventions and therefore both art exhibits were held simultaneously but, nevertheless, quite a number of Canadian artists and craftsmen were represented in both shows.

Fine Arts and Camera Salon

The Canadian Fine Arts and Camera Salon which is sponsored by the Frank W. Horner Company had the largest display yet exhibited and the available space was heavily overtaxed. Prize winners in these exhibits were as follows:

Fine Art

First Prize (Sir Frederick Banting bronze plaque)
Dr. G. E. Tremble, Montreal
"Open Water in March"

Second Prize
Dr. Anna D. Gelber, Toronto
"Off to Work"

Third Prize
Dr. Adrian Anglin, Toronto
"County Cottage"

Awards of Merit
Dr. John H. Toogood, Montreal
"Nephrutate de Soudan"
Dr. T. E. Brown, Lethbridge
"Winter Scene"
Dr. R. W. I. Urquhart, Toronto
"Line Camp"

Monochrome Photography

First Prize (Sir Frederick Banting blonze plaque)
Dr. G. B. White, Port Colborne, Ontario.
"Climax"

Second Prize
Lt. Col. C. G. Wood, Forbes P.O., Ontario.
"Gail"

Third Prize
Dr. Dominique Gaudry, Chicoutimi, Que.
"Les Grandes Eaux"

Awards of Merit
Dr. J. M. Ridge, The Pas, Man.
"The Padre of Port Hope"
Dr. F. F. Wait, Saskatoon
"The Operation"
Dr. W. P. Goldman, Vancouver
"Fishing Fleet"

Colour Transparencies

First Prize
Dr. J. F. Burgess, Montreal
"Pholiota"

Second Prize
Dr. E. A. Petrie, Saint John
"Sunrise"

Third Prize
Dr. W. K. Blair, Oshawa
"Lazy Days"

Awards of Merit
Dr. J. A. Hannah, Toronto
"Sleet"
Dr. Gilbert Parker, Toronto
"Spring Morning"
Dr. Cecil Young, Toronto
"The Philosophers"

The judges at the Fine Art and Camera Salon were: Mr. R. Y. Jackson, Mr. S. J. Vogan, and Dr. Harvey Agnew.

A.P.A.A.

The American Physicians' Art Association exhibition, which is sponsored by the Mead Johnson Company, was again given a strategic position among the educational and technical exhibits at the American Medical Association meeting and attracted much attention. Among the exhibitors were the following Canadian entrants:

Charles H. Best, M.D., Toronto
F. B. Bowman, M.D., Hamilton (award of merit)
T. E. Brown, M.D., Lethbridge
James Calder, M.D., Edmonton
Cyril Forssander, M.D., Victoria
J. S. Gladwin, M.D., Vancouver (award of merit)
Annie Hennegar-Sanford, M.D., Kennetcook, N.S.
M. Langlois, M.D., Quebec
Paul C. Laporte, M.D., Edmunston, N.B.
L. M. Mullen, M.D., Calgary
L. J. Notkin, M.D., Montreal (award of merit)
A. J. Pauly, M.D., Noranda
R. C. Riley, M.D., Calgary (award of merit)
R. L. H. Saunders, Halifax
Franklin E. Scribner, M.D., Gimili, Man. (first prize in needlework)
Robert M. Stringer, M.D., Hamilton
Harvey Agnew, M.D., Toronto (judge)

Among Canadian graduates living in United States the following were noted: Dr. Joseph E. Bellas, Peoria, Ill. (University of Manitoba); and Dr. Beaumont S. Cornell, Fort Wayne, Indiana, (University of Toronto).

We are pleased to note that Dr. Pearl Rose of Evansville, Ind., will take over the editorship of the A.P.A.A. Bulletin. As Dr. Pearl Summerfeldt before her marriage, she was well-known in Toronto through her research work at the Hospital for Sick Children. Her husband, Mr. A. L. Rose, vice-president of Mead Johnson and Company, and No. 1 Honorary Member of A.P.A.A. has been largely responsible for the rapid growth of the A.P.A.A. and is entitled to full credit for the highly successful annual exhibitions.

King's Fund Consultant Accepts I.H.F. Appointment

Capt. J. E. Stone, Consultant on Hospital Administration and Finance for the King Edward's Hospital Fund for London, was appointed last month as Honorary Secretary and Treasurer to the International Hospital Federation. The Federation was established for the collection of national literature on hospital work; for the holding of international hospital congresses, and for the publication of commission reports, with a view to improvement of hospital development, planning, and administrative practice. The first international hospital congress will be held in Holland in June, 1949.

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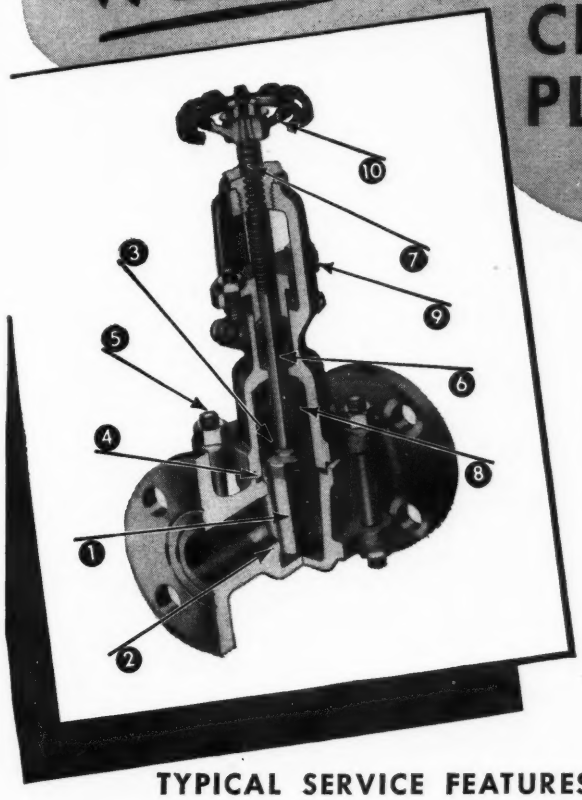

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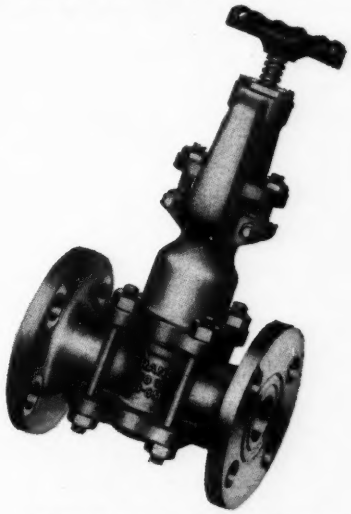

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With the Hospitals in Britain

By "LONDONER"

C. E. A. Bedwell

Dear Mr. Editor:

Although Canada is not faced with the problem of an aging population to the same extent as Great Britain, it is one of mutual interest. To the extent that the younger generation emigrate to Canada in response to the cordial invitations which they are receiving, so much will the proportion of the older age groups be increased in Great Britain. This, however, involves big questions of population policy affecting the whole of the Commonwealth and Empire, which are outside the scope of these pages. There is a hospital aspect which claims consideration here. It is being increasingly realized in Great Britain that there are far too many old people who are permanently occupying hospital beds. This condemns them to stunted lives when they might have much fuller and happier existences. Moreover with the mounting costs of the maintenance of hospitals it also involves an unjustifiable expenditure. This aspect of the subject was considered in a letter last year (April, 1947) in connection with the publication of a report by the Nuffield Foundation, which has now been supplemented by the report of an admirable inquiry into the conditions of a sample group of old people.

Wolverhampton was chosen for a medical survey of a cross section of the older age group of the population. It is a manufacturing town in the Midlands with a primary interest in the engineering trades. The population is approximately 150,000 in an area not sufficiently large to cause a segregation of different income groups nor so small that there was any difficulty in obtaining a random sample giving access to every income group from rich to poor. The selection was made by taking every thirtieth card from the ration cards and was very effective in the width of its range. It was by no means confined to one section of society. At the time of the interview one of the old people included was selling his business for £400,000.

Dr. Sheldon, to whom the task of making the medical survey was entrusted, is the Medical Director on the staff of the Wolverhampton Royal Hospital and has a practice in the town in which he has been a resident for twenty years. His report shows that he was eminently suited for the work, as he possessed the confidence of the old people and added a human sympathy to his professional interest in their welfare. The result is an illuminating description of the conditions of life for old people, especially in sickness, and is full of information for any who are concerned with their care.

On Making Life Happier for the Aged

The loneliness of old people is a point which stimulates sympathetic concern, but Dr. Sheldon found that many of them are only geographically lonely. An appreciable proportion living in houses by themselves were in the same street as near relations, who maintained regular communication and shared tasks. The strength of family life is an encouraging feature of the report. There is evidence that it exists in other towns in the Midlands and North though less in the newly developed areas of them. Social Workers in London particularly remarked upon this feature of his investigations, as it differs from their experience. Even when relatives live in the same street, it is not an uncommon thing for them to require stimulation to visit the old people. It is clear, however, that hospitals and other institutions can do much by providing more facilities for visiting and also greater liberty for the old people to go out to visit their relations.

The provision of spectacles is a subject upon which some of Dr. Sheldon's information is almost incredible. It was one of the most depressing aspects of the report. He found that not only do some subjects lack glasses altogether, but that in addition nearly one-third are using spectacles whose effect varies from inefficiency to positive harm. Here are some examples. A woman aged 74 has for the last twenty years used the glasses left by her sister on her decease. A man aged 80 adopted his father-in-law's glasses after the latter's death thirty years ago. A woman aged 80 years uses a pair of glasses given her by a friend which originally belonged to the latter's husband, now deceased. Naturally none of these is satisfactory but the pathetic aspect is that some of these old people have not known that the means of providing for them is available. The same has not been true of hearing aids as a good deal of experimental work has been necessary. A special committee of the Medical Research Council has completed its investigations, so that there should be a supply available as soon as the new national health service act comes into operation.

The care of old people in time of sickness, in their own homes, brought out another important point. It was not the assistance of a district nurse for which most of them were anxious. Either spouse wanted to do the nursing provided that they could have some form of home-help to assist with the other work of the house. Another point which arose in this connection was the evidence of strain experienced by old people in caring for some of the younger generation in time of sickness.

There are so many important and

(Concluded on page 84)

Provincial Notes

Nova Scotia

LUNENBERG. On the occasion of the 195th anniversary of the town of Lunenberg, hundreds gathered on Hospital Hill to participate in the ceremony of turning the first sod of the new hospital site. The spade of 195 years ago was replaced by a powerful bulldozer to make the first cut into the sod. Since the provincial government has offered assistance in financing the project, an early beginning on the construction of the hospital is now assured.

Quebec

MONTREAL. Work has commenced on the construction of a large nurse's residence and training school at St. Mary's Memorial Hospital. The new half million dollar building will provide space for private and semi-private accommodation for 106 nurses, an instruction and training school, reception and lunch rooms, kitchens, library, and roof sun-bathing pergola.

* * * *

MONTREAL. This summer the Red Cross mobile dental clinic is making a 3,000 mile tour of the north shore of the Gaspe Peninsula. The travelling unit, which is headed by Dr. J. P. Lanthier of Montreal, has additional facilities this year for anaesthesia. This free dentistry is a great benefit to those who otherwise might never see a dentist.

Ontario

FORT WILLIAM. Construction will commence shortly on the new wing of the Fort William Sanatorium, which, when completed will increase capacity from the present 222 beds to 308 beds. It is estimated that the new wing will be used almost entirely to care for new cases which may be discovered through x-ray surveys in the near future. The wing is financed by a Dominion government grant on the understanding that the hospital will care for approximately 75 Indians.

* * * *

FORT WILLIAM. The "Annex" of the McKellar Hospital, an innovation in hospital extension, was formally opened on June 11th by Premier Drew. The Quonset hut, which was adapted for this purpose, accommodates 34 chronically ill patients, leaving the main building for the care of the acutely ill. Divided into two wards of 17 beds each, the all-steel construction is thoroughly insulated against extremes of heat and cold. The annex, costing $34,000, half of which was contributed by the Ontario government, is served by its own nursing staff and supervisor.

* * * *

GODERICH. A feature of the official opening of the new wing of the Alexandra Marine and General Hospital on July 1 was the unveiling of a tablet in tribute to the charter members of the Ahmeek Chapter, I.O.D.E., which was organized in 1901 with the avowed intention of establishing a hospital in Goderich. In addition to the 25-bed wing, a new heating plant and laundry have been constructed, connected to the main building by a 150-foot tunnel.

* * * *

HAMILTON. In order to relieve beds in the General Hospital for patients requiring active treatment, construction of a new 200-bed convalescent hospital on the Mountain has been recommended by the Board of Governors of the General Hospital. Provincial and federal grants are expected to amount to $3,500 per bed.

* * * *

KINGSTON. The present D.V.A. hospital in Kingston will be transferred from the Department of Veterans Affairs to the Eastern Counties Tuberculosis Association, Dr. Bruce Hopkins announced recently. The hospital will be operated as a 150-bed institution on a temporary basis for three to five years until such time as a permanent structure is completed.

* * * *

KINGSTON. The Kingston General Hospital has opened a new department equipped with an electro-encephalograph. This machine has been spectacular in the diagnosis and location of cerebral tumors, and has proved invaluable in indicating cases of epilepsy and schizophrenia.

* * * *

MATHESON. The serious need of additional hospital space has brought to the fore proposals for a new 20-bed Red Cross hospital. The community, comprising eight townships with a population of approximately 4,000, is at present being served by a small ten-bed hospital operated by the Women's Missionary Society of the United Church. The new hospital site has been chosen and plans are underway for raising the necessary funds.

* * * *

MIMICO. Thomas Holmes, president of the Lakeshore chamber of commerce, has announced that a $600.000 hospital will be built to provide accommodation for the rapidly growing Lakeshore area. Present plans call for a 60-bed institution with room for expansion to 200 beds by 1960.

* * * *

OAKVILLE. The Oakville Lions Club recently contributed $1,000 to the Oakville-Trafalgar Memorial Hospital building fund. The board expects to receive $1,000 per bed from federal and provincial governments as aid for the construction of the $300,000, 40 to 45-bed hospital.

* * * *

OTTAWA. A building permit has been issued for a two-storey addition to the Ottawa General Hospital. Designed by architects Gascon and Parent, the building cost is estimated at $450,000.

* * * *

SEAFORTH. At a cost of $62,000, the new 27-bed wing of the Scott Memorial Hospital was completed and opened officially in July. Six

private and semi-private rooms, one four-bed ward, and two two-bed solaria are included in the accommodation. In the basement, space has been provided for a nurses recreation room, x-ray facilities and an emergency ward. A program of renovation and modernization is to be undertaken in the main hospital building in the near future.

Manitoba

DAUPHIN. On the occasion of the Golden Jubilee of the town of Dauphin, open house at the Dauphin General Hospital brought hundreds of visitors and friends to tour the hospital and view at first hand the many modern improvements of recent years. At present, a leading health centre in Manitoba, the well-equipped 100-bed institution is a far cry from the small frame structure of 1901. This year a new building is being constructed on the hospital site, including a health centre where the health unit, diagnostic unit and welfare offices will be located. A nurses' home is to be erected in the near future.

* * * *

WINNIPEG. It is expected that Princess Elizabeth Hospital for the Aged and Infirm will receive $416,000 from recently announced Dominion grants. With a bed capacity of 208, the hospital is at present one-third completed, and should qualify for a federal construction grant proportionate to the uncompleted portion of the project.

* * * *

WINNIPEG. To mark his retirement, Dr. F. A. Benner, medical superintendent of Grace Hospital, was given a farewell dinner in the Royal Alexandra Hotel. A gift was presented to him by Brig. V. Pearl Payton, superintendent of the hospital, who recently assumed her new office as Women's Social Service Secretary, with headquarters in Toronto.

Saskatchewan

PRINCE ALBERT. The opening of a new wing and power plant at the Victoria Hospital marked the growth of the hospital from an over-crowded unit of seven beds (in 1899) to the modern 160-bed institution. The wing features almost complete soundproofing provided by insulation under the floor covering and a paging system consisting of a private telephone exchange extending from central office to all parts of the hospital. Cost of the improvements, including the power plant, the new building, and the equipment, amounts to more than $265,000, and the growth which is indicated by these improvements has been attributed to the constant co-operation given by the city, its citizens, and in particular the Ladies' Aid Society.

* * * *

DELISLE. It was with great pride that people from Delisle and neighbouring towns flocked to the official opening of the Delisle Union Memorial Hospital. The $80,000 18-bed hospital was a whole-hearted community effort, furnished with modern equipment by homemaker clubs, women's organizations, and service clubs.

Alberta

CALGARY. Plans for the new 100-bed Junior Red Cross Crippled Children's Hospital have been approved and construction is already underway. The building, designed by W. L. Somerville, Toronto, is of fire-resistant construction, containing three four-storey wings. Owing to the desperate need for space for 100 children, one-half of the project is being built immediately with the funds on hand. The completed project will provide accommodation for 150 children and all necessary special departments and services.

* * * *

CALGARY. Major Nellie Jolly has been appointed superintendent of the Grace Salvation Army Hospital in Calgary. Previous to her new appointment, she was superintendent of nurses at Grace Salvation Army Hospital in Ottawa for nine years.

British Columbia

PORT ALBERNI. The board of management of the West Coast Hospital has instructed architects, Gardiner and Thornton, to proceed immediately with plans for a new hospital. More bed accommodation is required, as is also more adequate equipment, including a new power house and improved hot water and steam facilities.

* * * *

DAWSON, YUKON TERRITORY. St. Mary's Hospital, financed in its infant days by those who trod the golden trail of '98, celebrated its golden jubilee in June. Major additions since its beginning, including a new isolation and private room section known as "The Jubilee Extension", have brought the present bed capacity to 75.

Surgery of the Mind

In the field of psychosurgery there is currently increasing emphasis on the selection of candidates and differential operative techniques in connection with the brain operation known as prefrontal lobotomy. The subject is discussed by Dr. Burlingame of the Hartford Retreat, Hartford, Connecticut, in the annual report of that institution where he also stresses the importance of a post-operative program of resocialization.

"Diseases of all types produce habit patterns and invalidism to a greater or lesser extent and the mere performance of the lobotomy itself has failed to obliterate disease-induced habit patterns. Therefore it is evident that a study program of resocialization to teach socially acceptable behavior . . . is essential to realizing maximum benefit for the maximum number of operative cases."

Because lobotomy calls for a staggering amount of research before and after the operation, plans have been made to construct a complete psychosurgical unit as an addition to the neuro-psychiatric institute of the Retreat. This unit, which will be the first of its kind in the field, will include complete surgical requirements, living accommodation, classrooms and social facilities for 20 to 25 patients.

New Film

Crawley Studios of Vancouver, B.C. have produced a film entitled "Peace of Mind" for Plan for Hospital Care, Toronto. The film will be distributed across the Dominion.

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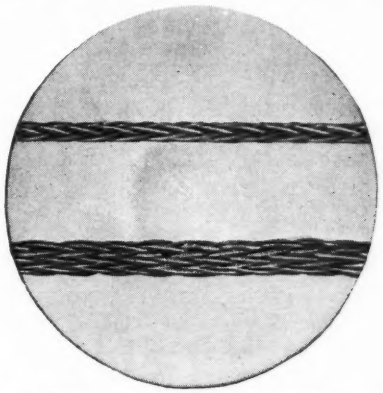
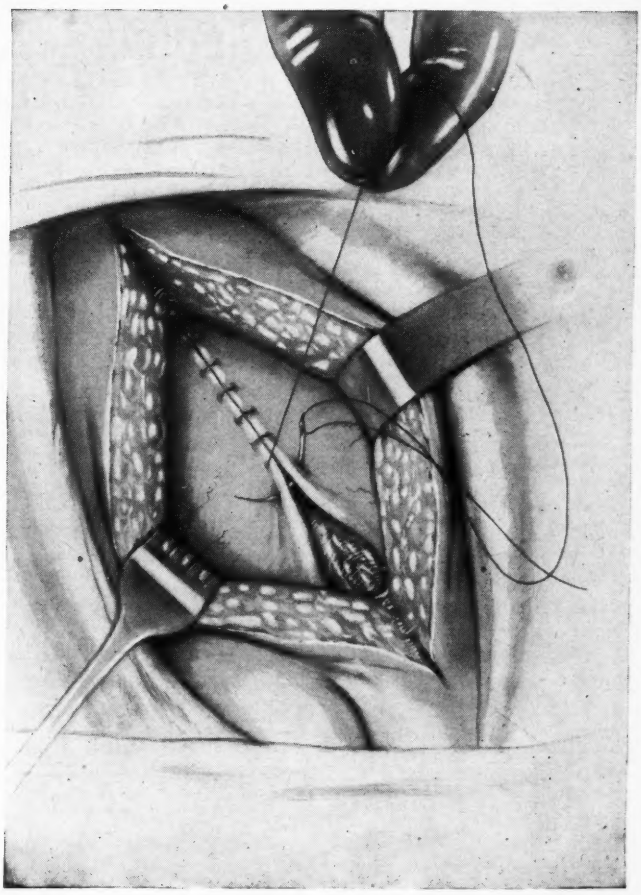


Many individual strands of wire are in Ethicon Braided Tantalum. Photomicrograph, above, shows Sizes 3-0 and 1, magnified to x15.



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Literature describing use of Ethicon Tantalum products available on request.

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Book Reviews

WIDENING HORIZONS IN MEDICAL EDUCATION. A Report of the Joint Committee of the Association of American Medical Colleges and the American Association of Medical Social Workers. Pp. 228. Price $2.75 (U.S.A.), 1948. Published by The Commonwealth Fund, 41 East 57th Street, New York 22, N.Y.

It is increasingly apparent that the rapidly changing society of the last two decades, branded by insecurity, anxiety and turbulence, has produced men and women who are overburdened with physical, mental and emotional disturbances. Medical men who undertake to cure these people, are becoming increasingly aware, too, that many physical and mental ills are inextricably interwoven with the social aspects of each case. This recognition and the teaching of the social and environmental factors in medicine has assumed impressive proportions and is the subject of an extensive survey and study made under the auspices of the Association of American Medical Colleges. In 1941, this Association appointed a sub-committee of the Committee on the Teaching of Public Health and Preventive Medicine to explore the subject of medical-social teaching. In 1943, the committee, now an independent body, continued the Study in collaboration with the American Association of Medical Social Workers.

As presented in this book, the Study generally aims at gathering pertinent information with a view to analyzing and evaluating it and offering recommendations. In relation to psychiatry, the emphasis is upon the utilization of the knowledge and skills which are an essential part of the equipment of the general practitioner and which are fundamental in acquiring the capacity to recognize, evaluate, and treat the social and environmental aspects of illness.

Part I contains general considerations, a summary of findings, and conclusions; Part II provides much of the source material, including the case study outlines and case reports. This is a book that will well warrant the intelligent and careful attention of medical teachers and students.

TEXTBOOK FOR ALMONERS. By Dorothy Manchée, Almoner, St. Mary's Hospital, London. Foreword by Sir Alfred B. Howitt, C.V.O., M.D., President, Institute of Almoners. Pp. 466. Illustrated. 1947. Published by Baillière, Tindall and Cox, London, W.C.2. Canadian Agents, Macmillan Publishing Company, 70 Bond Street, Toronto.

This comprehensive textbook on the place of the social worker in the hospital field, while based on British experience, is here drawn to the attention of Canadian readers because there is great need for further development of medical-social service work in this country. The term "almoner" is not used on this continent and in Britain the worker so designated has duties not delegated to social workers in our hospitals. The chief of these is responsibility for financial arrangements on behalf of indigent patients. In our hospitals all questions of payment are dealt with by the finance department, though sometimes with the assistance of a social worker. However, with respect to "follow-up" care, rehabilitation of the patient, and in acting as a link between the hospital and various social agencies, the functions of the almoner and of the medical-social worker here are comparable.

Miss Manchée's description of the origin and growth of the almoner service is a readable and very enlightening chapter in social history. She goes on to discuss standards of training for the almoner, the scope of her hospital work, her status and functions. The place of the almoner under national health insurance is discussed in detail, and the final section deals with the social aspects of disease.

Since it would seem inevitable that, with the eventual implementation of our new Dominion Government health proposals, medical social work will play a larger part in our scheme of social welfare, this book might well be placed in the libraries of all health and welfare departments as well as of hospitals.

Premature arterial degeneration means that bad material was used in the tubing.—*William Osler.*

Handbook on Fire Prevention

The 1948 edition of the N.F.P.A. Handbook of Fire Protection by Crosby, Fiske and Forster is now available and may be procured from the National Fire Protection Association, Boston, Mass.

In the words of the editor, Robert S. Moulton, the Handbook "is a complete revision of the 9th edition, published in 1941, with detailed treatment of numerous new developments in the fire protection field during the past five years and revision of all data that have become obsolete. Like the preceding editions, beginning with the first book published in 1896, the present edition aims to provide in compact form the essential information on fire prevention and fire protection that time has crystallized into good practice."

Capt. Stone Reports

In recent months, Capt. J E. Stone has made available to the public, in the form of a very readable pamphlet, the first section of his report of a visit to leading hospitals in the United States and Canada. The tour, which included hospitals in New York, St. Louis, Chicago, Battle Creek, Toronto, Montreal, Boston, Philadelphia, and Washington, was sponsored and financed by the King Edward's Hospital Fund for London. In the words of Capt. Stone, "the purpose of the tour was to establish personal contact with the leading hospital authorities, . . . and to obtain first hand information on a number of subjects, more particularly—the functions and organization of central funds; the development of hospital and health services; the planning of hospitals and methods of construction; hospital equipment and supplies; university training courses for hospital officers; medical records and the training of medical record librarians; and the methods of organizing and conducting hospital information bureaux and advisory services." This first Report does not aim at being comprehensive; however, it does present a careful and illuminating statement of the essential features of hospital planning and construction.

From the highest to the lowest have need of medicine.—*Robert Burton.*

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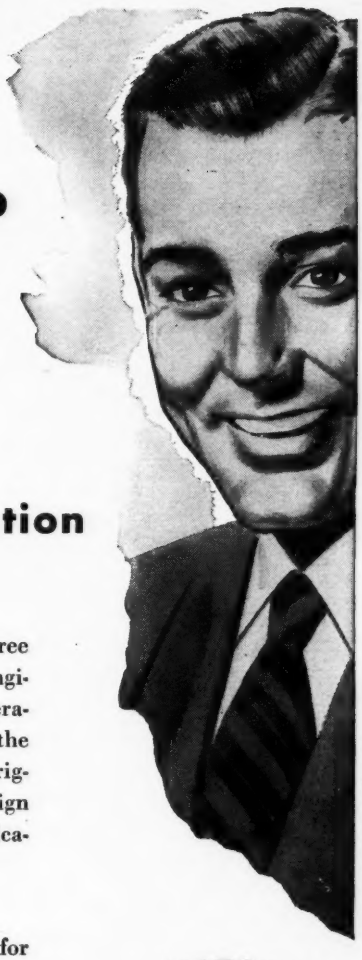

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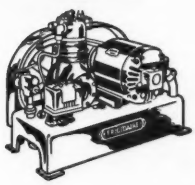

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How France Protects Children from Tuberculosis

DESPITE social and economic conditions which are still far from normal, France is taking definite steps to reduce the incidence of tuberculosis, and commendable results have been reported. Primary among the measures taken, is the work of safeguarding children, under the direction of the Ministries of Public Health, Work and Social Security, and National Education.

Department Centres, under the Ministry of Public Health, have been set up with sub-divisions called Maternity and Child Care Centres. When necessary, financial grants are made either directly or by the allotment of Social Security Funds.

Pre-Natal Care

Current legislation extends obligatory examination to all categories of women eligible for the various benefits—those disbursed by the State or public and Social Security funds. X-ray examination takes place during the third month of pregnancy. Examination of the father is obligatory before the fifth month of the mother's pregnancy.

When an expectant mother is recognized as being tubercular, she is immediately sent to an anti-tubercular "dispensary" which takes complete charge, either sending the patient to a nearby maternity clinic, a sanatorium, or one of the centres established for the care of tubercular expectant mothers. If the father is found to be infected, his care is taken over by the dispensary which removes him from proximity to the family.

Every member of the family who is likely to come in contact with the new-born child, is checked for active or incipient tuberculosis.

Post-Natal Care

When it has been established that a mother has tuberculosis, the child, after examinations over a six-week period to determine whether he is free of the disease, is placed in a foster home or at a supervised centre. Special hospital centres are provided for the children who have been contaminated.

At the present time there is no specific regulation as to when a child may be returned to a parent who has suffered from tuberculosis, and has been clinically cured. The creation of villages especially for these people, where they can live and work with their families, is considered a most favourable solution.

Contamination in a family of school age children constitutes only a minor problem. Under the direction of the Scholastic Hygiene services, there are currently clinical and x-ray examinations for tubercular reaction for children between the ages of six and fourteen. Stringent measures are taken to keep check on the teaching personnel and assistants. The "Préventoria" play an important role in the protective care of children in this group.

B.C.G. Vaccination

As a complementary measure to the separation of the nursing child from its contagious parent, B.C.G. vaccination is recommended for all infants and children of primary and secondary age whose skin-reaction test remains negative and who are placed in supervised family placement centres.

Special attention to the infants and children in France does not mean disregard of tubercular adults, but it is an attempt to prevent these children from becoming ill adults, and to mitigate the effects of this disease on the entire population.

Condensed from an article by Dr. Manuel Moreno, former house-physician of Paris hospitals. Courtesy French Information Service, Ottawa.

What Causes Unrest?

Surely it is failure to keep faith with the employee or to consider him as an individual who has interests and responsibilities in life outside and beyond the vocation by which he earns his living. Unrest and dissatisfaction go together. But the latter may, perhaps, refer more particularly to small irritations occuring in the particular environment in which the employee works.

I believe the best method of removing small dissatisfactions is to provide a suitable channel by which complaints can be aired and considered. I believe it is good policy to encourage complaints—not to repress them.

Trying to repress complaints is akin to adopting prohibition. An illicit complaint going in the wrong direction contains a tang for the complainant that has the attractiveness of a sly drink in a "speak easy". The trouble is that the "liquor" may be very expensive and harmful to both the employee and the institution.

Every employee is entitled to an answer when he asks a question. If the immediate superior cannot give an answer he should take up the question with someone who can. If the employee receives no answer from his immediate superior, he will take his question elsewhere. It is better to provide him with a path, along which he can carry it, than force him to air his grievance to someone who will capitalize on it to his own benefit. —*Percy Ward.*

Lighten the Burden of the Paying Patient

When a patient enters a hospital he has two concerns. One is that he will be given skilled, competent, and adequate care. The other is that the cost will not be too heavy a burden. Progress has been made in providing, for him, improved treatment and diagnostic facilities. Plans for Hospital Care and other insurance have helped those who were wise enough to participate, but it is unfortunate that the only revenue the hospital board controls is that which comes from fees paid by the pay patient.

It is right and proper that by himself, or through insurance, the private and semi-private patient should pay the cost of his own care. He should not, while sick, contribute anything for losses in the public section, for ready-to-serve cost, or for educational features. These items should be a responsibility of the citizens as a whole, and this is a desirable social measure.—*R. Fraser Armstrong.*

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Making Committees Effective

From an article by Edward F. Sheffield in "Food for Thought", the publication of The Canadian Association for Adult Education.

THE other day I was talking with the secretary of a large and important committee. "We've got to get rid of the dead wood," he was saying. "Look at the list. McCracken, Dingle and Bishop haven't been to a meeting for months. Thornton and Smith turn up fairly regularly, but have you ever heard either of them say a word? And then there's Bulcher. I suppose his name is worth something, but so far as I know he has never shown his face here. If it weren't for Crutchlon and Timmins and Roberts and men like them, we'd be in a bad way. They're the ones who do the work."

Members' Duties

Good committee members attend meetings regularly, and on time. They take part in the discussion and work of the committee. Basically, of course, each member must have a real interest in the task of the committee and in the organization of which it is a part. If this is present, attendance and active participation are encouraged . . . if members are prepared for meetings by advance notice, given responsibility for parts of the committee's work and led to expect satisfaction from committee meetings, they will attend and do their share.

On whom, then, rests the responsibility for seeing that these conditions are met? On the chairman and the secretary.

Chairman is Key Man

The role of a committee chairman is a demanding one. As spark plug of the group he takes the initiative in calling meetings, in outlining the committee's task, in planning agenda, in stimulating co-operative action by committee members.

Like the presiding officer of a formal meeting, he superintends the committee in operation, keeping order in discussion, checking irrelevancies, promoting full consideration of business before the meeting and assisting the group to reach its decisions.

Like the leader of a discussion group, he presents the problem (or arranges for it to be presented), encourages discussion by drawing out individual members, assists the group to realize its progress by making intermittent summaries of agreement to date, taps sources of information pertinent to the discussion by locating useful printed material or inviting people with specialized knowledge to sit in with the committee as advisers.

A committee chairman does all of these things. In addition, he is expected to know at least as much, if not more, about items on the agenda as do the other members, and to take an active part in discussion. His special genius is in his ability to facilitate the integration of group thought by feeling and giving expression to the sense of the meeting by practising what Helen Husted calls "platform telepathy". Thus does he both focus and reflect the thought of the group.

In *The Ottawa Journal* recently, I. Norman Smith described General A. G. L. McNaughton's almost ideal chairmanship of the Security Council of the United Nations in these words:

Towards the end of the same day, after many delegates had stated their views, . . . General McNaughton summarized the debate and submitted his intended plan of the council's next move—all in the course of two and one-half minutes . . . I attended the Security Council every day last week and not for one moment did I see him in other than rapt attention . . . His notes trace the main developments in argument, the differences, the weaknesses. And so it was that at the end of a four day debate . . . he was able himself, without any warning as to when that debate was going to end, to sum up for the council in factual fashion the state of the argument and the line of attack into the next phase.

The chairman's performance is the key to a committee's success. Next in importance is the role of the secretary.

The Efficient Secretary

Efficiency is the watchword of an efficient secretary. He helps the chairman plan agenda, sends out notices of meetings and reminds members just before the scheduled date. At committee meetings his chief task is to keep the minutes—a record of decisions reached and progress made. Frequently, if the committee is to prepare a report the secretary drafts it.

These duties should not preclude the secretary's participation in discussion, for often his careful analysis of the on-going work of the committee enables him to make especially significant contributions to the group's thinking. Other than efficiency, the talent most to be prized in a secretary is the ability to distinguish between the important and the unimportant, the relevant and the irrelevant, and to keep records which reveal what are truly the highlights of the committee's work.

A good secretary can provide the kind of support and stimulus which enable a good chairman to be outstanding, and every member a satisfied worker.

Medical Change

That there has been in the past decade a complete revolution in our thinking, concerning government's relation to the duties and privileges of all classes of people, is beyond dispute. But the fact that the resulting social upheavals are bound to influence deeply every occupational group and class, seems to have escaped many leaders of those various groups. The government and social set-up of a nation cannot undergo radical re-organization and change, and yet allow a selected few of its constituent groups to stand still. When medicine, or industry, or any other group in a rapidly changing society, will within its own group fight all change, it brings into play the old law of a moving body striking a stationary force. Something is bound to be smashed—and in our case that something is medicine, unless we in medicine can get moving in a constructive way.

—From New York Medicine

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Hospitals and Government

(Concluded from page 28)

of a government system of compulsory health insurance. And it was thought that this Assembly was simply to be another sounding board to provide propaganda for that program. The fact that a group of people interested in health and welfare programs (only about half of them being representatives of the professions) could, and did endorse prepayment plans seems to be an indication of the strength of this principle and its effectiveness in providing a good means of distributing our services. Development of the prepayment principle was the second point of the Association's program for providing care to our people.

As a third point, we said that government has a definite responsibility in providing adequate care for persons unable to pay for it themselves. Our platform urged, however, that this should not be done exclusively by a central government. We said it should be a matter of local participation and responsibility to the fullest extent possible with whatever financial assistance might be provided by the federal government. Senator Taft and others introduced a bill rather early in the last session of Congress, which would have put this principle into effect in a manner which our Council on Government Relations generally approved. However, a battle developed between sponsors of this porgram and those who believe that the federal government ought to take over the whole program of administrating medical and hospital care through a compulsory health insurance plan. There were hearings before the committee making the study and the Brookings Institution was asked to review the arguments on both sides, and make a report. Its report, as recently published, simply opposed a compulsory health insurance program at this time by exposing fallacies in many of the arguments which have been presented in its support. This subject is still under discussion.

There have been many changes in the hospital field in the last generation. We have seen the development of elaborate and frequently miraculous surgery. Our so-called wonder drugs are the talk of every tongue. Our remarkable progress is perhaps best illustrated by the story of the man who notices a friend with a bad case of sniffles. "What's the matter", he said, "Got a cold?" "Yes,", was the reply, "I'm having an awful time with it." "It's too bad you don't have pneumonia; they know what to do for that."

We have seen amazing changes in our social structure too. Families who would formerly have cared for their own sick and injured now prefer them to be hospitalized not only for the sake of better treatment but from the standpoint of family convenience. This is particularly true in our cities and wherever the population has become very dense.

We have made some progress in our economy too. We have developed Blue Cross plans which have taken many people out of the charity class and made them self-dependent. On the other hand hospitals, like every other part of the community, have been beset by inflationary costs and the rising spiral of wages and prices.

Government, too, participates in this constant change. Our taxes and expenditures for just the peacetime operations of government are far beyond anything we ever dreamed of a decade ago. And it does not appear that these expenditures will be substantially reduced within the foreseeable future. In fact, there is an increasing clamour that government take on more and more responsibility; indeed, we are a part of the clamour when we insist that the provision of medical and hospital care to the indigent is a proper responsibility of government. It seems quite probable that as our society becomes more complex there will be a continued tendency to pool our efforts and our resources through government action.

Against this background of shifting scenery hospitals must chart their course. We are due for changes. Many of the changes will come about through increasing participation of government in our activities. In this situation it seems to me that our approach must be to remember that in both of our countries the government is our government and responsive to our needs and our direction. In the field of providing hospital and medical care we are perhaps better qualified than any other group to give direction and leadership. This places upon us the responsibility of guarding those values which we know to be essential and of developing those improvements which we know must be made in order to furnish better care for our people.

We justify our existence by our usefulness. Our usefulness may be not only in providing service, but also in guiding the development of that service to the end that adequate medical and hospital care may be available to all of our citizens.

"The Hospital Pharmacist"

A new periodical has appeared which undoubtedly will be of great interest and value to those engaged in the pursuit of hospital pharmacy. Published bi-monthly by the Canadian Society of Hospital Pharmacists, *The Hospital Pharmacist,* as yet in the infant stage of its third mimeographed publication, can nevertheless boast of containing over 60 pages of instructive and readable material. Here the reader will find a fund of information, whether it be a timely editorial, an introduction to new products, a recipe for hand lotion or fly spray, or an article on "The Small Hospital and the Full-Time Pharmacist". The Editor, P. C. Statia, and his staff will welcome any contributions, and these should be submitted to the Publication and Editorial Office, 28 Herlan Ave., Kitchener, Ont.

The Value of Standards

It is a long time since a Greek philosopher remarked that men cannot hope for success in life without a knowledge of standards, but it is just as true today, as it was 2,400 years ago.

Standards help the school pupil, the beginner at work, the master craftsman, the shop foreman, the general manager and the president; they guide professional men and statesmen; they are of use to everyone in judging sports, work and goods for sale.

There are people who rebel. They don't like this or that rule, though a million others may approve it. If every rule and convention and standard objected to by someone were wiped out, there would be a state of confusion worse than that in Alice's Wonderland, where people made up their own rules as they went along.—*From a Monthly Letter of the Royal Bank of Canada.*

The Clinical Laboratory

(Concluded from page 36)

pital boards think the costs of establishing and maintaining an adequate laboratory service are too high. One way of reducing these costs is to employ a pathologist to supervise the laboratory services of two or more neighbouring hospitals and to pool certain facilities to avoid duplication of equipment and technicians. Unfortunately, too often conflict exists between the management of neighbouring hospitals, which makes it difficult or impossible to get together. Non-medical superintendents frequently do not fully appreciate the value of laboratory services to his or her hospital. Some hospitals are more concerned about establishing the more spectacular services such as radiology. X-ray equipment, like laboratory equipment, is costly. Salaries paid to radiologists and radiological technicians are much higher than those paid to clinical pathologists and laboratory technicians. Too great a disproportion exists between x-ray fees and those for laboratory service. This has created much resentment and hard feeling between clinical pathologists and radiologists. Comparisons are always odious but I have often wondered which would cause the greater hazard to the welfare of the patient, if the x-ray service suddenly broke down, or if the laboratory services were suddenly suspended. It is in cancer diagnosis that the pathologist reigns supreme. He is the final court of appeal. A grave responsibility rests upon him, especially in rapid frozen section diagnosis, for an incorrect diagnosis may be the means of a patient unjustly losing a limb, an eye, part of his stomach or a lung, which operation may cost the patient his life.

Recommendations

One should not criticize or oppose any plan without valid reasons and he should have an alternative plan and helpful suggestions to offer in its place. These are my suggestions:

1. Develop the laboratory service for your hospital. It will pay you big dividends, perhaps not in dollars and cents (although it can be a revenue-producing department) but it greatly enhances your prestige. Accuracy in diagnosis is increased and the standard of medical practice in your community is raised. If they cannot get the service they desire at one hospital, doctors will take their patients elsewhere, even at considerable inconvenience. Establish resident laboratory services if at all possible.

2. How is the scarcity of well-trained clinical pathologists to be overcome, and how can promising young medical graduates be attracted into this special field? First of all, recognize the importance of laboratory services to the hospital and grant the pathologist a position equal to that of other department heads. He should be paid a salary commensurate with his services. He should be provided with adequate equipment, technical assistance, and good working accommodations.

3. An inadequate supply of trained laboratory technicians also exists at present. To overcome this situation more training schools for Class C technicians should be established and larger numbers of persons should be trained in this field. This type of work offers a worthwhile vocation for the person who does not wish to proceed with a university education or enter a professional career. A limited number of laboratory assistants are being trained in our three-year university degree course and will be available for more responsible laboratory appointments. However, an adequate salary and good working conditions are necessary to attract the right type of person into this work.

4. To arrange for the services of a trained pathologist in a supervising and consulting capacity to the small hospital, it may be necessary for two or more neighbouring hospitals to combine the services of one pathologist, whose headquarters would be established in one hospital, thus reducing the costs of laboratory services and avoiding duplication of equipment and technicians. Another way of reducing the cost of laboratory services is to raise the laboratory fees. At present, in general, they are much too low and not in keeping with their importance as diagnostic and therapeutic aids.

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Hospital Purchasing

(Concluded from page 45)

ing agency, the one operated by the Cleveland Hospital Council for the past 29 years, has estimated in their 1947 report that they are responsible for a saving of 5 per cent to their 13 member hospitals and other institutions. However, in common with other buying agencies they stress the fact that they are a service organization or procurement agency not designed for the specific purpose of saving their members money.

Each organization supplies a particular service, as in the case of the Hospital Bureau of Standards and Supplies of New York where they have testing facilities for the purpose of closely checking quality. They work in conjunction with various other organizations such as the American Hospital Association for the purpose of compiling standards, but at the same time they endeavour to enter into contracts that would be advantageous economically to their member hospitals. It would seem apparent that they are successful in this respect.

It very frequently happens that an individual hospital can obtain better prices on some particular item than is available to their co-operative purchasing group. This is often an indirect benefit partly due to the fact that these groups are not viewed with favour by industry.

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National Conference of Canadian Blue Cross Plans

The first national conference of Canadian Blue Cross plans was held at St. Marguerite's, Quebec, on June 2 and 3. The meeting was under the chairmanship of E. Duncan Millican, executive director of the Quebec Hospital Service Association and Blue Cross Commissioner for Region 12, i.e. the Dominion of Canada.

The executive directors in session passed a resolution supporting the formation of The Canadian Council of Blue Cross Plans to co-ordinate and extend the Blue Cross principle on a national basis in Canada. It was unanimously decided that, after the resolution had been ratified by the separate boards of directors, Dr. F. W. Routley, Acting Executive Director of the Plan for Hospital Care in Ontario, be named chairman of this Canadian Council.

Administrative discussions by the comptrollers resulted in concrete proposals which indicate that Blue Cross has the administrative machinery and trained personnel required to handle records of increasingly large numbers of participants and to serve large and small groups either locally or on a national basis. A proposed national contract which might be offered to employees of national accounts was also given consideration. The fine spirit of co-operation in evidence throughout the meetings, proves that Blue Cross can and will expand its sphere of usefulness to the Canadian people.

Among those present at the meeting were: Walter Welsford, Vancouver; Dr. F. W. Routley, Messrs. Sage, Ogilvie and Robertson of Toronto; Messrs. Millican, Durnford, LeBlanc, and Brown, Montreal; Miss R. C. Wilson, Mr. Doyle and Mr. Downing of Moncton, N.B.

* * * *

Eight Provinces Now Covered by Blue Cross

The organization of a new Blue Cross Plan, under the Associated Hospitals of Alberta, brings the number of plans in Canada up to six and these now provide hospital service benefits in eight of the nine provinces. The Alberta plan has its headquarters in Edmonton and enrollment was begun on July 1st. The co-directors are Joseph A. Monaghan and Harold D. Stacey.

1947 Report of Insurance Research Fund

The Third Annual Report of the Life Insurance Medical Research Fund, which has recently been published, comprises a valuable survey of the research projects sponsored by this organization. Supported solely by the U.S. and Canadian life insurance companies, the Fund during 1947 contributed a considerable share of all money spent in these countries for research in cardiovascular diseases. Grants from the Fund supported research programs and established medical fellowships for 38 trained scientists, five of whom were Canadian. In all, the Fund has given about two hundred thousand dollars for these fellowships and over a million and a half dollars for specific research projects.

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Or, the requirements of your practice may definitely point to the need for a 'cardiograph that provides somewhat wider use. When there is a greater number of outside calls, for example, a smaller, lighter weight instrument may be more desirable. Also, in locations where there are different types of electric current, or the complete lack of it, the battery operated instrument is often the solution to the problem.

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The Auxiliaries

North Bay Auxiliary Shows Active Interest

Now that the new Queen Victoria Memorial Hospital is a certainty, the women of North Bay have taken a renewed interest in the activities of the Women's Auxiliary. An all-out spring membership drive netted 1080 members and, in May, a tag day brought in receipts amounting to more than $600. A feature of this day was the use of coloured crepe paper flowers, an attractive departure from the ordinary tag. Results of the efforts of the past two months, which included new rugs and drapes purchased for the living rooms of the Nurses' Residence, were displayed at a summer tea to the ladies of North Bay.

* * * *

A.H.A. Conference of Women's Hospital Auxiliaries

Of interest to women, is the A.H.A. Conference of Women's Hospital Auxiliaries to be held concurrently with the A.H.A. Fiftieth Anniversary Convention in Atlantic City, September 20-23. Morning sessions of the Conference will feature programs on auxiliary groups. In the afternoon, conference women will join with convention delegates to hear addresses by national leaders on topics of wide concern to those in the hospital field. The names of all women planning to attend the Conference should be sent to Mrs. Anna Mantel Fishbein, Chairman, Women's Hospital Auxiliaries, 18 East Division Street, Chicago 10. Registration for the Conference will take place on Sunday, September 19, at the Traymore Hotel, Atlantic City.

* * * *

Hospital Aid Organized at Southampton, Ont.

In recent months the ladies of Southampton have been aware of the need for an active hospital auxiliary which would function in connection with the new Saugeen Memorial Hospital. Such a need was met in the organization of an Aid, whose duties were explained by Miss Margaret West, superintendent of the hospital. The new officers include Mrs. H. W. Harmer, president, Mrs. A. H. Parker, vice-president, Miss Beatrice Dey, secretary, and Mrs. W. H. Carson, treasurer.

* * * *

Walkerton Women's Institute Plans Renovations

Members of the Women's Institute recently undertook to renovate the room in their charge at the hospital. In order to raise the necessary funds for the paint and new furniture required, it was decided to operate a booth during the Old Boys' Reunion.

New Grants May Cut Rates

As a direct result of the new hospital tax on amusements, maintenance grants paid by the Ontario Government to 155 hospitals were more than doubled in the first quarter of the current fiscal year. From April 1 to June 30 grants totalled $1,275,334 as compared with $512,058 for the same period a year ago. Grants for the year will total more than $5,000,000 and it is hoped that this increase may lead to a reduction in hospital rates.

Textile Problems in the Laundry

Textile problems in a laundry are many, and outstanding among these is shrinkage in both cotton and wool. Since for the most part hospital linens are cotton, I will deal with that fabric.

Prior to the war textile manufacturers, working hand in hand with the laundry industry, introduced preshrunk materials which became known to the trade under the name "sanforized". Articles bearing this label could be subjected to high temperature laundering which, incidentally, is so essential to hospital linens, without the slightest fear of shrinkage. However, applying this treatment to cotton at the time of manufacture resulted in considerable yardage loss, with the result that most manufacturers *discontinued the practice*, leaving the shrinkage of the material for the consumer and laundry to fret about. Whether the discontinuance of this was intentional or merely an attempt to conserve cotton, I cannot say, but if for the latter reason, then I believe they laboured under misapprehension, for I am quite sure that many made-up articles had to be discarded due to normal shrinkage. I personally know of at least three size sixteen shirts that, after laundering, came out size fifteen, which resulted in their life ending before it had begun and, no doubt, some of you had similar experiences. I am pleased to announce, however, that the American Institute of Laundering, and the National Research Institute, Ottawa, have again been working with textile manufacturers and the result of their work is in evidence as you have no doubt observed. Advertisements in widely distributed magazines once again ask the buying public to refrain from buying other than laundry tested articles bearing the seal of the laundry institutes.

At the Vancouver General Hospital we have for some considerable time been preshrinking all material before making it up. As a matter of fact, we do this also with materials sent to outside firms for manufacturing. It is true this costs a little money but our *children's ward* cannot possibly use any more adult garments. One textile headache, happily left behind when I transferred from the commercial field, was colour bleeding. Hospital linen, for the most part being white, relieves the institutional laundry of this trouble. In this regard, also, the previously mentioned laundry institutes have been instrumental in having manufacturers re-introduce tub-fast colours, which reduces bleeding to a considerable extent. Therefore, in my opinion, the laundry department can supply our purchasing agent with valuable assistance in these textile matters and the purchase of linens generally. As a matter of fact I will go further and say that, wherever possible, *linen purchases in quantity* should not be made until samples of the merchandise have been laundry-tested in your own plant. Our purchasing agent avails himself of this service and, I believe, finds it very helpful.

—From an address by G. Ruddick at the Two-day Hospital Administration Course, Victoria, 1947.

Analysis of Experience with Surgical Benefits

Boys incur 15 per cent more surgical operations than girls, with 60 per cent of all children's operations being tonsillectomies and 20 per cent appendectomies or fractures, according to an analysis of 100,000 surgical benefit claims of persons of all ages made by a committee of the Actuarial Society of America and presented at their annual meeting in May.

This was one of a long list of findings from the study which covered group surgical insurance claims reported by companies doing 70 per cent of this type of insurance and covering a period of eight months of last year.

Eight types of operations were found to account for the greater part of all surgical benefit claims: tonsillectomy, appendectomy, benign tumour or cyst, haemorrhoidectomy, fracture, hysterectomy, herniotomy and dilation or curettage. These accounted for 60 per cent of all claims—57 per cent of the male cases and 67 per cent of the female cases.

Multiple operations take place in a large number of cases, taking advantage of the urgency of the major cause. In 17 per cent of all cases, more than one operation was performed under the one procedure; in the case of claims for wives, 31 per cent were multiple, for female employees, 24 per cent, for male employees, 15 per cent and for children 5 per cent. In gynecologic surgery, a maximum of 51 per cent was shown.

More complicated surgery was incurred at ages over 50 in the case of men. For women, the operations were generally more serious than for men at all ages, but the severity changed little with age, except for a slight peak in late child-bearing or post child-bearing years.

Not all surgery is performed in hospitals, the report shows, though most of it is. Men show a higher out-of-hospital surgery incidence than women. In the case of men, 23 per cent of the operations were performed out of hospitals, for children, 16 per cent and for women, 11 per cent. The average amount paid for out-of-hospital claims was less than one-third that for hospital surgery.

Analysis of surgical fees in the cases covered showed that charges were highest on the west coast, with California showing the highest cost of any state. In California the charges were 39 per cent greater than the U.S. average in non-obstetrical cases and 61 per cent over average in obstetrical; in the middle Atlantic states, the next highest, the charges were 3 per cent and 5 per cent higher than average, respectively. The south Atlantic states showed the lowest cost, 12 per cent and 9 per cent, respectively, below average.

The average surgical claim for male employees was $48.00, for female employees $63.00, for wives $71.00, for male children $34.00 and for female children $37.00.

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6. Steam chest not sufficiently hot.
7. Natural tendency of certain types of fabric to roll up.
8. Improper starching or sizing, or use of improper starch or sizing in the washwheel.
9. Static electricity which attracts the linen being ironed, much in the manner of a magnet.

The remedy, in every case except Nos. 7 and 9, is a matter of proper mechanical adjustment of the ironer, and selection and use of the proper materials. In the case of item 7, the work may have to be hand finished or ironed on a press. In the case of item 9, it may be possible to ground the ironer by means of a copper wire attached to the ironer and to the cold water supply pipe, as a means of carrying off some of the static electricity developed by the ironer.

When goods stick to press covers it is probably due to the starch or sizing in the linen, or the cover cloth may be old and loaded with starch. Certain types of cover cloths are now made to overcome sticking.

—From "Technical Bulletin", Canadian Research Institute of Launderers and Cleaners.

Coming Conventions

August 8-23—C.H.A. Institute, Quebec City.
Aug. 23-25—Quebec Conference C.H.A., Quebec City, P.Q.
September 6-18—A.C.H.A. Institute for Hospital Administrators, Chicago.
September 18-19—American College of Hospital Administrators, Traymore Hotel, Atlantic City.
September 20-23—American Hospital Association, Convention Hall, Atlantic City.
Week of Oct. 4th—Western Institute for Hospital Administrators, Hotel Vancouver, Vancouver.
Oct. 14-15—Saskatchewan Hospital Association, Saskatchewan Hotel, Regina.
Oct. 18-19—Manitoba Hospital Association, Royal Alexandra Hotel, Winnipeg.
Oct. 18-22—A.C.S. Clinical Congress, Biltmore Hotel, Los Angeles.
November 1-3—Ontario Hospital Association, Royal York Hotel, Toronto.
November 8-10—Associated Hospitals of Alberta, Palliser Hotel, Calgary.

Responsibilities of Trustees

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staff remuneration. In latter years, hospitals in the Maritimes have been losing vast sums annually by deliberately selling hospital services to various responsible government bodies at figures far below cost. In New Brunswick alone, in recent years, this loss of revenue to public hospitals has exceeded $200,000 annually. It is suggested that this is but one example of the manner in which our hospitals have been poorly operated. These annual amounts alone would go a very long way in paying present hospital staff salaries sufficiently attractive to make them happy in their work and thus retain their services. Other improvements in hospital financing could pave the way for raising the whole scale of remuneration and also provide for additional staff.

Hospitals in Britain

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practical points in Dr. Sheldon's report that it is difficult to cover even the outstanding ones. However, one point demands attention by all who are concerned with the establishment of a system of insurance in Canada. The anticipation of life lengthens every year, yet Great Britain has instituted a system of insurance requiring retirement at an age when a man, in the words of Dr. Sheldon, "suddenly finds himself deprived of his round of activities while still in full possession of his skill and experience". If for economic reasons and the benefit of the rising generation he must give up his normal occupation, which in itself is a doubtful proposition, then let him be provided with an alternative to occupy his time in those years in which he will be faced with the difficulty of finding that life is worth living. Any other course is inhuman.

The General Practitioner in the Role of Psychologist

The most urgent need of our civilization is a family doctor who can see the human organism as a composite whole and deal with it physically and psychologically according to its individual needs. The consummation of this ideal is best achieved in the rural community.... It is doubtful if there has been a period since the time of Hippocrates when science, in cold calculation, has so readily discarded the *art* of medicine. It is equally doubtful that humanity, though blessed with the gift of science, has ever been so in need of human understanding endowed with the primal sympathy of man for man.

It is well for the general practitioner to remember that approximately 80 per cent of the people who call for a doctor are good for spontaneous recovery without the aid of medicine, but they would have a poor time psychologically without the advice of a wise doctor.

Finally, when illness strikes, it is of paramount importance to know how to stay the storm, to soothe the soul, to quiet the heart, and restore psychological balance, thereby helping to establish physiological equilibrium. This is the general practitioner's perennial privilege, rarely the specialist's.

—Lewis J. Moorman, M.D., in "Rocky Mountain Medical Journal."

Control of Linen

(Concluded from page 34)

made by the central linen room from accumulated soiled linen receipts and this recapitulation gives the quantity of clean linen, to be returned by the laundry the following day, to make replacements for the issues made on the day represented by the recapitulation.

Staff apply directly to the central linen room for issues of clothing where linen cards are made out listing receipts for which their signatures are secured. They also return soiled clothing directly to the soiled linen room where receipts are obtained which, when presented to the central linen room, entitle the bearer to items listed thereon. This does not necessitate any change in the individual's linen card. When a member of the staff is discharged his last salary cheque is withheld until a clearance has been received from linen stores indicating that all items listed on his linen card have been returned.

It will be seen from the above that the system in operation in Sunnybrook Hospital is the old, efficient "straight exchange method" which is familiar to everyone. The inventory charged against the central linen room may be checked at the end of each day, and it is readily seen that the items on the shelves, plus the recapitulation of the soiled linen receipts, should equal the amount shown on the inventory board. The same applies to the linen closet on each ward, the totals of the items shown on the linen cards in the office of the charge nurse, plus the clean linen in the clean linen closet, plus the soiled linen in the soiled linen closet, should equal the amount shown on the inventory board.

Ideal, but—

The system described appears to be ideal and perfect, but does not work as well as it sounds. Considerable loss may be experienced in the linen closets on the wards, and this is entirely due to the lack of control that may be exerted over the individual concerned with the custody of the linen on the wards, when personnel is changed three times in 24 hours. With the chain of responsibility being broken in this manner, any deficiencies which occur always occur in the other person's shift or tour of duty; consequently, unless positive proof can be produced that the loss actually occurred at a certain time, this excuse prevents any disciplinary action being taken. In addition it may be said that of all those concerned with the custody of linen, the nurse is the least appreciative of the amount of control required for the proper protection of a supply that can quite easily represent several thousands of dollars a year in deficiencies.

The following points are worthy of consideration in instituting a system of linen control:

(1) A schedule of stacking and bundling should be encouraged throughout the entire institution for both clean and soiled linen. This allows rapid checking of inventories and speeding up of issues with less likelihood of errors in counting;

(2) Do not have more than bare necessities in the linen closets, as it is from this point that most deficiencies occur;

(3) Have the chain of responsibility for the custody of linen as restricted as possible.

Food Poisoning Affects Hospital Staff in Winnipeg

An outbreak of food poisoning at Grace Salvation Army Hospital recently affected about three dozen nurses and other staff employees, causing moderate to violent illness. Medical authorities attributed the poisoning to some chemical agent sprayed on the vegetables. Provincial and city health officers have undertaken a food analysis, but as yet no definite word has been received concerning the results of their investigations.

Paid With Interest

The faith of the Municipal Hospitals, Winnipeg, in the inherent honesty of the average citizen was considerably enhanced upon receipt of a cheque for $123.45 from a resident of Alberta. The cheque was for payment of an account of $62.50 dating back to December, 1928, and long since forgotten.

An accompanying letter explained that the family's financial circumstances, which were extremely poor in 1928, had improved during the past few years, but the account had been overlooked until discovered among some old papers. Interest at five per cent for the entire period was included in the cheque.

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Nursing Service

(Concluded from page 42)

but it is taking on increasing importance. Here the nursing staff must be well trained and have more time for adequate participation in the program. The centralization of inhalation therapy and the care of post-operative patients in a room near the the operating suite are examples of changes which widen the scope of nursing and give the patient improved care.

8. The hospital endeavouring to take its place as a health center.

This presupposes not only adequate facilities but teaching patients and personnel acceptable health practices. Establishing plans for the follow-up of patients after discharge requires a knowledge of community facilities and making necessary contacts. Some hospitals employ a public health nurse to supervise this broader phase of patient care, while others carry it out with regular personnel including social service.

9. The use of extensive sedation during labour.

Professional nurses are needed constantly at the bedside to observe and safeguard the patient.

10. The recognition of nursing service personnel as individuals with the privilege of working in a situation which provides at least a fair degree of satisfaction and an opportunity for advancement.

Here, one can mention, among other items, the shorter work week, better salaries, time off and on duty planned as far in advance as possible, and an in-service educational program.

Today, there are more patients returned to health through the progress of medical science. There is a high utilization of hospital facilities, beds, operating rooms, delivery rooms, and diagnostic equipment. Savings have been made in lives, and physical and mental trauma. Health plans are big business. Little is said about *how* these were accomplished, and especially the changes in group activities which made them possible—nursing, dietetic, and other patient service departments. A few of those in nursing have been recorded for your interest and help. Providing more bedside care with fewer nurses, even though more are available now than ever before, is a problem which can be met only by joint participation of hospital administrators, heads of other hospital departments, nurses, and doctors. The answer in nursing is not in recruitment alone, or reducing the length of preparation, decreasing the age requirement, or giving less education; rather, it requires also intelligent use of nursing personnel based upon continuous analysis of the situation.

Accumulated Shock Causes Accidental Death

The death of a patient at Douglas Memorial Hospital, Fort Erie, Ont., was caused by accumulated shock, shock sustained before admission from a fall which caused hip and leg injuries, and additional shock indirectly resulting from a short circuit in an x-ray machine. Although the patient was not directly injured by the machine, she saw the technician thrown to the floor in a semi-conscious condition. First aid was administered to the technician but attempts to revive the patient were of no avail. Investigation of the x-ray equipment is under way.

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